American Optometric Association
NEWS™

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HHS releases new HIPAA regulations

Most optometrists will need to take a few additional steps to protect patient information in their practices under the new Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules issued Jan. 17 by the U.S. Department of Health & Human Services' (HHS) Office for Civil Rights (OCR), according to the AOA.

The AOA urges members to make plans now to update their HIPAA policies, procedures, and documents.

The association is developing new member resources to assist optometrists with this process.

"The new HIPAA privacy and security regulations will effectively require most optometric practices to review their privacy and security policies, update the Notices of Privacy Practices (NPPs) they provide to patients, and take a few additional measures to ensure the privacy, security, and accessibility of patient information in their practices," said Jon

see HIPAA, page 6

Critics say VSP's online dispensary will push patients toward Internet

A new online eyeglass dispensary, now being test-marketed by VSP Vision Care under the name "Eyeconic," has the potential to disrupt more patient-practitioner relationships than it creates, according to AOA Board of Trustees member David O. Cockrell, O.D. The insurer's dispensary website is being test-marketed to VSP clients in Oklahoma, with direct mailings to plan beneficiaries offering incentives for use before Feb. 28, 2013. A national rollout to all 55 million VSP members is anticipated sometime this year.

A national rollout to all 55 million VSP members is anticipated sometime this year.

If VSP follows through with its nationwide marketing plan, it will become the largest vision plan actively encouraging consumers to purchase prescription eyeglasses through a website instead of a doctor's office, a pivotal boost to Internet sales at a time when the

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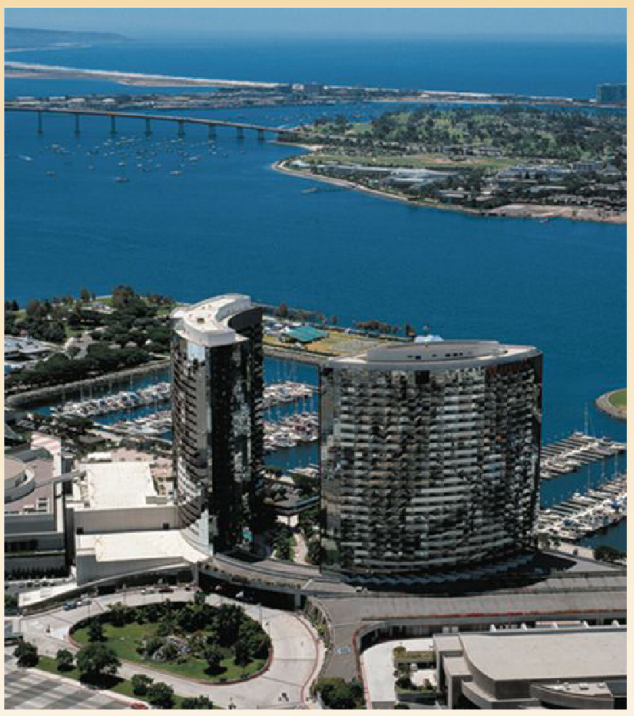
Sunny San Diego



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AOA calls on HHS to reject proposed barrier to kids' essential care

Opposition pressure groups launch massive new attack on AOA's position

As the U.S. Department of Health & Human Services (HHS) takes its final steps toward implementing the Affordable Care Act's essential health benefits (EHB), the American Academy of Ophthalmology (AAO) and groups representing health insurers and business interests are lobbying the agency hard to reverse course on its pediatric vision care EHB proposal by erecting a new barrier between kids and the eye and vision care they need.

The anti-access coalition's pediatric vision care recommendations stand in direct contrast to what the AOA, Congress, and HHS know the benefit needs to be for America's families.

In the ongoing legislative and regulatory battles in Washington, D.C., the AOA has successfully advocated to make expanded and direct access to comprehensive eye care a national health care priority. The AOA wants to ensure that coverage for at least an annual comprehensive eye exam and follow-up care is the foundation of the newly created pediatric vision essential benefit.

Ophthalmology and insurers have actively opposed the AOA at each step of the process and are now pursuing a last-ditch effort to roll back eye health and other coverage requirements before they can take effect next year.

The AOA is calling on the HHS to reject outright the ophthalmology-led group's vision screening benefit recommendation that places a new and dangerous barrier between kids and the comprehensive eye and vision care that they need to learn and grow.

Essential Health Benefits Coalition recommendations

Consisting of the AAO, the Blue Cross and Blue Shield Association, America's Health Insurance Plans, the National Association of Manufacturers, and others, the so-called "Essential Health Benefits Coalition" delivered a lengthy letter to the HHS last month pleading for the agency to reduce access to benefits, including essential eye care, by implementing six recommendations for shaping the final EHB rule in a way the group claims will make coverage less costly.

> *One of the key items on the anti-access EHB coalition's wish list is a demand that the HHS gut requirements for pediatric vision benefits by giving medical doctors, employers, and insurance companies the means to keep patients from seeing optometrists.*

One of the key items on the anti-access EHB coalition's wish list is a demand that the HHS gut requirements for pediatric vision benefits by giving medical doctors, employers and insurance companies the means to keep patients from seeing ODs.

Overall, the proposal calls for the HHS to allow participating health insurance plans to downgrade the HHS' benchmark vision benefit to one that "follows the American Academy of Pediatrics' Bright Futures' recommendations for preventive dental and vision screenings, with referral for necessary vision, medical and surgical care for potential problems as needed."

For pediatric vision services, Bright Futures' recommendations call for risk assessments up to age 3, a vision screening at ages 3, 4, 5, and 6 with a risk assessment at age 7, and, in general, alternating a screening and risk assessment beginning at age 8 and continuing through childhood and into adolescence.

The group assures that "if a risk assessment indicates a potential issue, an eye examination including refraction would occur."

However, acknowledged research and OD experience shows vision screenings miss most eye and vision problems and even problems identified by a screening often remain unresolved because, tragically, the appropriate transitions into care do not usually occur.

The anti-access group's letter also offers a dangerous alternative should HHS officials again reject a screening-based benefit. It contains a final and desperate plea for the HHS to create a gaping loophole in the final EHB rule by including a special provision through which "insurers may require a referral from a primary care provider, school or health department prior to receiving vision benefits."

The coalition adds that "the referral should identify the need for additional care following a screening/risk assessment consistent with Bright Futures guidelines."

In an apparent effort to create a new gatekeeper system, the group's recommendation would universally require that kids first fail a vision screening before gaining access to any other eye and vision care service.

AOA efforts

Through grassroots advocacy efforts over the last three years, AOA doctors and staff have worked alongside key members of Congress to press for a pediatric vision benefit based on direct access to optometry and covering comprehensive eye exams and follow-up care.

On behalf of America's children, the AOA has consistently and repeatedly delivered this message directly to HHS leadership and the agency's staff experts, who have agreed at each step of the process that the pediatric vision care benefit should be centered on a comprehensive eye exam, not a screening offered alone or as part of a well-child visit.

With state-based health insurance exchanges expected to be up and running later this year and enforcement of EHB requirements at the start of next year, the AOA expects the HHS to release its final EHB determination in the coming months.

For the latest coverage on the AOA's children's vision advocacy, visit *http://bit.ly/ZnxTwj*. AOA members with questions on this important topic and those seeking to get more involved in federal advocacy should contact the AOA Washington office at 800-365-2219 or *ImpactwashingtonDC@aoa.org*.

SYVM focuses on nutrition, eye health

Everyone's heard the saying "you are what you eat." Well, it's true for your eyes as well as for your heart, bones and teeth. During AOA's Save Your Vision Month, the AOA reminds Americans that caring for eyes includes looking carefully at what you eat.

"Six Essential Nutrients Your Eyes Need" is a convenient, mini tear sheet offered free of charge through a generous educational grant from Kemin Health. Item NG-3 is available at *www.aoa.org/onlinestore*.

Six nutrients — antioxidants lutein and zeaxanthin, essential fatty acids, vitamins C and E and the mineral zinc — have been identified as helping to protect eye sight and promote eye health. Because the body doesn't make these nutrients naturally, it's important that they are incorporated into a daily diet and, in some cases, supplemented with eye vitamins.

More than two decades of extensive research have provided a better understanding of how diet and nutrition can not only keep our eyes healthy, but reduce the risk of certain eye diseases as we age. From dry eye to age-related eye diseases, research shows that nutrition plays a critical role in maintaining the health of our eyes.

Key eye nutrients in fruits and vegetables

The AOA recommends eating a diet with a variety of foods loaded with key

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How does your board think?

Whenever I visit a state meeting and talk about how your AOA leadership deals with an issue, everyone's ears seem to perk up a bit. So let me share some insights and give you an example of how your board thinks.

First, and probably foremost, you should know all AOA Board members are in practice and that is how they support themselves (and no, we aren't financially supported by the AOA). Also did you know that five of the 11 AOA Board members are also married to optometrists who are in practice as well? Many of those practices are quite different, and some of us are, or have been, on faculty or have practiced in the VA or military and other modes of practice as well. So *everything* we look at first goes through the filter of 11 practitioners and how it will affect our members in their practices both today and tomorrow.

When we started planning for this year, about a year and a half ago, I was able to lead a meeting that lasted several days where I began with two important realizations: first, the world is changing and membership organizations must change and adapt to be successful; and second, and more important, we agreed that associations become successful by helping their members become successful. So those are our two next filters.

At that meeting we did a comprehensive review of all of our AOA activities, programs, and services. Then we looked at each one's value to our members. Finally, we looked at what programs to continue, revamp or discontinue. As a result, we made several changes in the AOA structure and volunteer community this year.

The biggest changes occurred in how we communicate, and we focused on making our communications better. First, let me say we realize that communication is a two-way street. So we not only looked at what information we send out and how we send that information out, but more importantly, we looked at strengthening how we listen and take information in. Good communication requires information to flow both ways to be successful. Information flow in either direction is a challenge!

The result of that analysis has been a full revamping of our communications at AOA. Each board member frequently travels to state meetings and other events to visit with our members and listen and learn about what their concerns are and to hear about optometry in their state. The average trustee travels about 90 days a year, while the executive committee hits around 110 days traveling a year and the president hits around 160 or so days a year. Also, each board member holds quarterly calls with all the state leadership. Recently we looked into how we can make those calls more effective – especially focusing on improving the interactions on those calls and listening more than talking.

Additionally, this year we also started quarterly calls between the executive staff of the state and the AOA Affiliate Relations and Membership staff. We appreciate the 75 percent of affiliates that participate on these calls, but I frankly wish we had 100 percent participation – it would help everyone's communications! In any case, I hope those states know we are trying to reach out and connect.

We also greatly expanded and reorganized our Communications Group, and we now have exceptionally talented volunteers and staff involved with AOA Communications. One of the new committees is the Public Affairs Committee, which is specifically looking at what our message is to the outside world and how we can best deliver that message. One activity this committee focuses on is the public awareness campaign.

Another important new committee is the Association Communications committee. This is a bit of a new concept for the AOA, and this committee looks at AOA print and electronic communications directed to our members with the goal of how we can best communicate with our members. Increasingly, the AOA also tracks open rates of email blasts and looks when and what is the most effective way of communicating. We reduced the number of emails sent out by 18 percent last quarter and increased our open rates by 1 percent.

Another pioneer communications effort is the Publications and Education committee, which evaluates the *AOA News*, EyeLearn™ and future publications to improve their value to members. For example, you will see some great improvements to *AOA News* and increased practical clinical content very shortly. As the AOA puts more effort into educating and helping our members adapt to the changes we are all facing, I am hopeful in the future we will be able to greatly expand this portion of AOA activities into a true Center for Education.

Dr. Hopping

Interestingly, we have found that all parts of our communications efforts are related, and so frequently these committees work together to create an even better and more effective communications effort. This was particularly true for our new website design that you will see soon.

We all know that it is easier to talk to our patients face to face, and anytime we communicate over long distance it becomes more challenging. But all that being said, I think your board's continued responsiveness to every email, every letter and every phone call is a significant indication of our desire to communicate with all of our members!

So how does your board think? Your board thinks like volunteer practitioners looking for the best ways to help our members in their practice, who want to hear from our members and want our members to receive the best information possible to help them adapt and succeed in our changing world. It's as simple as that!

Ronald L. Hopping W.

Ronald Hopping, O.D., MPH
AOA president

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HIPAA,

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Hymes, AOA Advocacy Group director.

The HIPAA Privacy and Security Rules take effect March 26; however, covered entities and their business associates generally will have until Sept. 23, 2013, to comply with most of the rules' provisions.

The new, revised HIPAA regulations provide updates to the HHS' initial set of privacy and security protection rules.

The role of technology in the optometric practice has changed since the HIPAA legislation was initially passed in 1996, and the HIPAA regulations needed to be updated to reflect those changes, Hymes said.

"The new rules put into place several provisions aimed at updating patient privacy safeguards while also recognizing how information needs to be made securely accessible today and into the future, including through electronic communications," he said.

Most notably:

- Patients will now be allowed to request an electronic copy of their electronic health record.
- Patients will have the right to instruct their doctors to not share information about treatment with the patient's insurance company when the patient pays cash for the services rendered.
- Additional information will be required on Notices of Privacy Practices including information regarding patients' rights following breaches of protected health information and information regarding a patient's rights when paying for services out of pocket.

In addition to making sure their practices are in compliance with the updated federal privacy and security rules, practitioners should make sure any business associates with access to protected health information, such as billing firms or claims clearinghouses, are aware of the new rules and are taking steps to adhere to them, the AOA Advocacy Group recommended.

Under the new revisions, the privacy and security rules will apply not only to health care practitioners and their business associates, but, for the first time, the subcontractors of those business associates.

The new privacy and security rules essentially offer health care practitioners an opportunity to review and update their patient information protection policies and procedures – a step they are actually required to take periodically under HIPAA.

"Throughout the development of these new regulations, the AOA has been engaged representing the interests of our members to ensure that patient privacy is respected and that optometrists do not face any unfair treatment or discrimination or any unnecessary compliance burdens," Hymes said.

Like the original HIPAA security rule, the newly revised security regulation requires health care practitioners to conduct a "gap analysis" of the measures taken to protect electronic protected health information (ePHI) in their practices. (See overview article on same page of *AOA News*.)

A list of answers to frequently asked questions regarding the new HIPAA regulations is posted at *www.aoa.org/HIPAA*.

AOA members with specific questions regarding the new HIPAA Privacy and Security Rules can contact Kara Webb in the AOA Washington office at *KCWebb@aoa.org*.

Members with questions about how to implement these changes in their practices should visit *www.excelod.com/HIPAA*.

Updated HIPAA regulations: What ODs need to know

The Health Insurance Portability and Accountability Act (HIPAA) patient privacy protection processes optometrists implemented years ago have now become routine for doctors, staff members, and patients. With the issuance of the new regulations, now is the time for optometrists to update their compliance procedures.

The U.S. Department of Health & Human Services (HHS) changed some of the requirements, and practitioners face bigger penalties for noncompliance. Here are some basic concepts that optometrists should understand as they begin to identify the changes that may need to be made in their practices.

Please note the AOA provides guidance on HIPAA by citing relevant provisions of the HIPAA regulations. This guidance should not be construed as legal advice. Practitioners are encouraged to contact an attorney for legal guidance. For additional information, see the "Updated HIPAA Regulations: What Optometrists Need to Know Now" frequently asked question document at *www.aoa.org/HIPAA*.

HIPAA: the federal health care privacy law

The HIPAA Privacy and Security Rules are federal law. The Privacy Rule gives individuals rights over their health information and sets rules and limits on who can look at and receive health information. The Security Rule delineates safeguards to protect health information in electronic form and helps to ensure that electronic protected health information is secure.

Who must comply?

Individuals, organizations, and agencies that meet the definition of a "covered entity" must comply with HIPAA. An optometrist is considered a "covered entity" if he/she transmits any information in an electronic form in connection with a transaction for which the HHS has adopted a standard. For example, submitting an electronic claim to Medicare or another payer is such a transaction. To determine if you are a covered entity, visit *www.cms.gov/Regulations-and-Guidance/HIPAA-Administrative-Simplification/HIPAAGenInfo/AreYouaCoveredEntity.html*.

Notice of Privacy Practices

Most covered entities (including optometrists) are required to have a Notice of Privacy Practices (NPP). An NPP describes uses and disclosures of protected health information a covered entity is allowed to make. The NPP also includes the covered entity's legal duties and privacy practices with respect to protected health information. A patient's rights with regard to protected health information is also included in an NPP.

Business associate agreements

According to the HHS, "The HIPAA Rules generally require that covered entities and business associates enter into contracts with their business associates to ensure that the business associates will appropriately safeguard protected health information. The business associate contract also serves to clarify and limit, as appropriate, the permissible uses and disclosures of protected health information by the business associate, based on the relationship between the parties and the activities or services being performed by the business associate. A business associate may use or disclose protected health information only as permitted or required by its business associate contract or as required by law. A business associate is directly liable under the HIPAA Rules and subject to civil and, in some cases, criminal penalties for making uses and disclosures of protected health information that are not authorized by its contract or required by law. A business associate also is directly liable and subject to civil penalties for failing to safeguard electronic protected health information in accordance with the HIPAA Security Rule."

Breaches of protected health information

"Breach" is generally defined as the unauthorized acquisition, access, use, or disclosure of protected health information that compromises the security or privacy of such information. Health care practitioners may be required to notify affected patients, the HHS, and even the media in the event of a breach of health information protected under the law. If the protected health information is secured by encryption, the security or privacy is generally not considered compromised and the incident is not considered a breach, so the risk assessment and subsequent reporting is not required.

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Documentation key in EHR audits, CMS says

The best documentation a health care practitioner can have in the event of a Medicare or Medicaid EHR incentive program audit is a computer-generated report confirming compliance with the U.S. Department of Health & Human Services' (HHS) electronic health records (EHR) "meaningful use" criteria, according to the U.S. Centers for Medicare & Medicaid Services (CMS).

Should a practitioner's EHR not be capable of generating such a report, paper worksheets, used by the practitioner when attesting meaning use, could be an acceptable substitute, if the worksheets together offer a full and detailed summary of the steps taken to qualify for incentive program bonuses, according the CMS.

However, practitioners should also be able produce additional documentation including "screenshots" taken at the time of attestation to demonstrate EHR functionality, patient records, and correspondence with other health care practitioners or entities documenting interactivity among EHR systems, the agency said.

The CMS launched a program of post-payment audits for recipients of Medicare and Medicaid EHR incentive bonuses last fall in response to an HHS Office of Inspector General (OIG) report.

The report noted that under Stage 1 of the incentive program, the CMS is issuing bonuses to practitioners who report or "attest" compliance with the programs' EHR utilization standards using a specially designated website.

However, the agency has no way to confirm at the time of attestation that a practitioner has actually met the required utilization criteria. (See "EHR incentive recipients subject to audits, CMS says," *AOA News*, September 2012.)

Under the new post-payment audit program, when providers are found not to be eligible for an EHR incentive payment, the payment will be recouped.

"The primary documentation that will be requested in all reviews is the source document(s) that the provider used when completing the attestation," the CMS noted in a posting in the "Frequently Asked Questions" section of its website. That document should provide a summary of the data that supports the information entered during attestation.

> *The provider should be able to provide documentation to support each measure to which he or she attested.*

"Ideally, this would be a report from the certified EHR system, but other documentation may be used if a report is not available or the information entered differs from the report," the agency added.

The summary document, which will be the "starting point" for all audits, should include at minimum:

- The numerators and denominators for the measures
- The time period the report covers
- Evidence to support that it was generated for the eligible professional who attested meaningful use.

Although the summary document represents "the primary review step" in an audit, auditors could ask practitioners to provide additional and more detailed documentation for any meaningful measures, including reviewing patient records.

"For that reason, all providers attesting to receive an EHR incentive payment for either the Medicare or Medicaid EHR Incentive Programs should retain all relevant supporting documentation (in either paper or electronic format) used in the completion of the Attestation Module responses," the CMS noted.

"The provider should be able to provide documentation to support each measure to which he or she attested, including any exclusions claimed by the provider," the CMS said.

Examples include:

- Drug-drug/drug-allergy interaction checks and clinical decision support – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.
- Electronic exchange of clinical information – Screenshots from the EHR system or other documentation that document a test exchange of key clinical information (successful or unsuccessful) with another provider of care. (Alternately, a letter or email from the receiving provider confirming the exchange, including specific information such as the date of the exchange, name of providers, and whether the test was successful.)
- Protect electronic health information – Proof that a security risk analysis of the certified EHR technology was performed prior to the end of the reporting period (e.g., report that documents the procedures performed during the analysis and the results).
- Drug formulary checks – Proof that the functionality is available, enabled, and active in the system for the duration of the EHR reporting period.
- Immunization registries data submission, reportable lab results to public health agencies, and syndromic surveillance data submission – Screenshots from the EHR system or other documentation that document a test submission to the registry or public health agency (successful or unsuccessful). Alternately, a letter or email from registry or public health agency confirming the receipt (or failure of receipt) of the submitted data, including the date of the submission, name of parties involved, and whether the test was successful.
- Exclusions – Documentation must be provided to support each measure exclusion claimed by the provider.
- Clinical quality measures (CQMs) – Save the documentation that supports the values entered in the Attestation Module for CQMs.

Providers selected for auditing will receive an initial request letter from the CMS' audit contractor. The request letter will be sent electronically by the audit contractor from a CMS email address and will include the audit contractor's contact information. The email address provided during registration for the EHR Incentive Program will be used for the initial request letter.

The initial review process will be conducted at the audit contractor's location, using the information received as a result of the initial request letter. Additional information might be needed during or after this initial review process, and in some cases an on-site review at the provider's location could follow. A demonstration of the EHR system could be requested during the on-site review.

A secure communication process has been established by the contractor, which will assist the provider in sending any information that could be considered sensitive. Any questions pertaining to the information request should be directed to the audit contractor.

States will have separate audit processes for their Medicaid EHR Incentive Program. Practitioners requiring additional information about those audits should contact their state Medicaid agencies.

Additional information on the documentation necessary to demonstrate compliance with federal EHR incentive program standards can be found using these resources:

- *http://tinyurl.com/bvxkrh7*
- *https://questions.cms.gov/faq.php?id=5005&faqId=7711*
- *www.aoa.org/ehr.*

What you need to know for Medicare EHR audits

Among the most daunting aspects of a Medicare EHR Incentive Program post-payment audit may be documenting compliance with Meaningful Use Core Measure 15. The measure requires health care practitioners to conduct or review a security risk analysis in accordance with federal regulations, correct any identified security deficiencies, and then implement any security updates as necessary.

The U.S. Centers for Medicare & Medicaid Services (CMS) defines the technical capability to protect patient information under Measure 15 using the 13 EHR certification and standards criteria below.

Practitioners called on to document compliance with this measure, as part of a Medicare EHR Incentive Program post-payment audit, should be able to produce evidence that the steps outlined under each of the criteria were taken during the EHR reporting period to protect patient information. In many cases, EHR systems may be able to generate reports documenting compliance with

See Audits, page 12

Optometrists enter crucial year with PQRS: 2013

By Rebecca H. Wartman, O.D.

Since the Physician Quality Reporting System (PQRS) was first introduced in 2007 it has continually evolved, bringing us to this pivotal year. While there are only a few minor changes to the program for 2013, it is an important year. Any provider who does not participate in 2013 will be penalized in 2015. (See "PQRS reporting required in 2013 to avoid 2015 payment cuts" in the January edition of *AOA News*.) Successful reporting means recognition for providing quality care for the individual doctor and for the optometric profession, as well as compensation for optometrists and avoidance of the 2015 penalties.

For successful reporting in 2013, the provider must choose at least three PQRS measures and report them consistently on at least 50 percent of the appropriate claims. This does not mean a provider needs to file three different PQRS measures on each claim.

To make PQRS 2013 reporting simple, there are only three diseases of concern to the optometrist: age-related macular degeneration, glaucoma and diabetes. (See diagnosis chart on page 13.)

The general ophthalmological examination codes (92002, 92012, 92004, and 92014) and/or the evaluation and management (E&M) codes to report examinations (99201-99205 and 99212-99215, including nursing home or rest home E&M codes, etc.) are the only examination codes of concern when reporting 2013 PQRS measures. Other eye care procedures do not trigger opportunities for reporting.

The 2013 PQRS codes are reported only on patients with traditional Medicare or Railroad Medicare, and who have one or more of the three diseases, and whose visit is billed using an E&M code or a general ophthalmic visit code.

Another important key to reporting for PQRS 2013 is to link each Quality Data Code (QDC) with only one applicable diagnosis even when more than one diagnosis code is applicable to the QDC.

The bonus payment for successfully participation in the 2013 PQRS will be 0.5 percent of your entire Medicare allowables filed for 2013. The bonus applies to any and all Medicare claims filed by a provider whether or not the visit is eligible for the addition of a PQRS measure code.

Why participate?

Why should optometrists participate in the PQRS program?

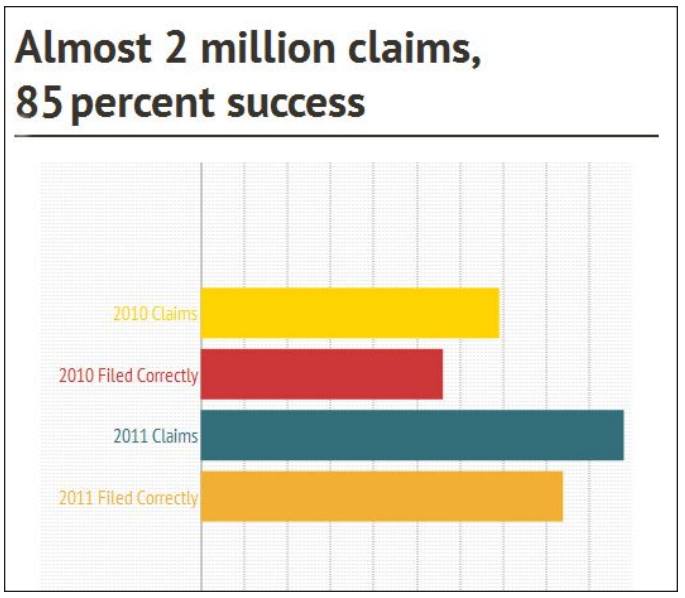
The primary reason for 2013 would be to avoid the 1.5 percent reduction in all your Medicare reimbursements for 2015. The second reason for participating is earning the 0.5 percent bonus for all your Medicare payments for 2013: more money is more money.

Finally, consider what the Centers for Medicare & Medicaid Services (CMS) is telling our patients. On the Physician Compare Website, Medicare lists the practitioners who have successfully participated in PQRS for 2011 (or 2010) with the following statement: "This professional chose to take part in Medicare's Physician Quality Reporting System and reported quality measure information satisfactorily for the year 2011 (or 2010)." Further, the CMS states: "A physician or other healthcare professional can choose whether to report quality information to Medicare under the Physician Quality Reporting System. Medicare believes that reporting quality information by professionals is an important means to improve the quality of care provided to Medicare beneficiaries."

Whether true in reality, this last statement gives the distinct impression that providers who participate in this program provide better care than those providers who do not participate. Your patients are reading this information and making judgments on the quality of your care. Eventually, the CMS will be providing reports to your patients on your actual performance under PQRS.

How did optometry perform in 2011?

Optometrists submitted 1,958,366 codes in 2011 (an increase of 29.5 percent over 2010) with a success rate of 85.64 percent (improving by 4.49 percent over 2010). The leading error again was incorrect diagnosis codes paired with PQRS measures, accounting for 12.93 percent of the errors. The two other leading errors were incorrect age matching for the measure and incorrect pairing of the CPT® codes with the PQRS measure. See the chart above for a comparison between 2010 and 2011 reporting periods. The payments for 2011 PQRS were sent in the third quarter of 2012.



PQRS 2012 measure details

Nine eye care measures were retained for 2012, and two new measures were added. Optometry only needs to be concerned with seven of these measures.

- Measure 12 –Primary Open-Angle Glaucoma (POAG): Optic Nerve Evaluation
- Measure 14 – Age-Related Macular Degeneration (AMD): Dilated Macular Examination
- Measure 18 – Diabetic Retinopathy: Documentation of Presence or Absence of Macular Edema and Level of Severity of Retinopathy
- Measure 19 – Diabetic Retinopathy: Communication with the Physician Managing

See PQRS, page 13

Overview,

from page 6

Patient access to health records

Patients will be guaranteed additional access to their health records under the new regulations. The regulations will allow patients to request electronic copies of their patient health information. The new regulations specifically require health care providers to provide electronic information to a patient in the electronic format requested by the patient, if it is readily producible, or, if not, in a readable electronic format as agreed to by the health care provider and the patient.

Patient rights when paying out of pocket for services rendered

In a significant change for the previous HIPAA regulations, patients who pay out of pocket for treatment can prohibit their health care practitioners from disclosing their health information to a health plan. The regulations require that optometrists agree in most cases to a patient's request to restrict disclosure to a health plan of the patient's protected health information that pertains to a health care service for which the patient has paid the health care provider in full out of pocket.

Penalties

The penalties for noncompliance range from $100 to $50,000 for each HIPAA violation. A maximum of $1.5 million will be assessed for violations of the same provision in one calendar year. The HHS will take into account a number of factors in determining the financial penalty. Issues such as the extent of the violation, the harm of the violation and other factors will be considered. If your state has additional privacy protections that are more stringent than the federal regulations, you are also required to comply with those state provisions.

Compliance deadline

Optometrists have until Sept. 23, 2013, to comply with the rule unless an exception applies.

FDA advisory panel ignores Congress, calls for new restrictions on pain meds

Over the objections of the AOA and national provider groups representing dentists, nurse practitioners, physician assistants and others, a U.S. Food and Drug Administration (FDA) advisory panel on Jan. 25 voted 19 to 10 in favor of moving hydrocodone-combination drugs, such as Vicodin and Lortab, from schedule III controlled substances into the more restrictive schedule II category. If allowed to be fully implemented, this action could block many ODs from prescribing these drugs.

For many ODs and other provider groups opposing the change, it would mean no longer being able to prescribe hydrocodone-combination drugs at all in some states.

The advisory panel's review of the issue follows last year's successful effort that convinced Congress not to make the very same change in how hydrocodone is classified.

After meetings with doctors and staff representing the AOA and state affiliates, including the West Virginia Association of Optometric Physicians, key lawmakers agreed last June to remove the hydrocodone reclassification provision from the Prescription Drug User Fee Act reauthorization bill before the legislation came up for a final vote.

The AOA views the advisory panel's action as misguided and incomplete and has already begun urging the federal officials who will soon review it to discuss the modifications needed to safeguard optometry patients.

In addition, the AOA is also educating officials about the important role that optometrists play in helping to fight addiction and guide patients into treatment.

Overall, the push to reschedule hydrocodone-combination drugs, a move sought by the U.S. Drug Enforcement Administration (DEA), has been aimed at curbing near-epidemic levels of abuse and diversion of opioids nationwide, though no organization nor individual official has ever cited optometry's prescribing authority as being a contributing factor to the problem.

Addiction counseling groups have also been calling for the rescheduling by arguing that the drugs are pharmacologically similar and as susceptible to abuse as other opioids that fall into the more tightly regulated schedule II.

Testifying on behalf of AOA at the FDA Drug Safety and Risk Management Advisory Committee meeting, Jimmy Bartlett, O.D., explained optometrists' role in caring for a majority of eye problems that most people commonly have and warned that, while abuse and diversion of these drugs are issues to be taken very seriously, simply moving hydrocodone-combination drugs into schedule II would have harmful health consequences for patients and would limit proven treatment options for providers.

For many ODs and other provider groups opposing the change, it would mean no longer being able to prescribe hydrocodone-combination drugs at all in states that have not specifically granted schedule II prescribing authority.

For other health care providers, moving the drugs from schedule III to schedule II would impact the ability to prescribe up to a six-month supply and remove the option to call-in a prescription instead of issuing a paper version.

At every step in this process, the AOA has reminded officials that optometrists are among law enforcement's most committed allies in the battle against illicit drug use, often serving as sentinels in the early detection and identification of abuse and linking individuals at risk to necessary health services.

Alabama optometrist Jimmy Bartlett, O.D., standing at the podium to the right of the screen, testifies on behalf of the AOA during the Jan. 24-25 FDA advisory committee hearing.

As outlined under the Controlled Substances Act, the advisory committee's recommendations will now be delivered to FDA leaders, who will in turn make a recommendation to the U.S. Department of Health & Human Services (HHS).

Following the Act's guidelines, HHS will then make its official medical and scientific evaluation on this issue to the U.S. Drug Enforcement Administration, which has the ultimate authority on the scheduling of controlled substances.

ODs concerned about the advisory panel's decision and interested in working with Dr. Bartlett and the AOA Advocacy Group to ensure that optometry's concerns are heeded going forward are urged to contact Matt Willette of the AOA Washington, D.C., office at 800-365-2219, ext. 1001 or *mwillette@aoa.org.*

Cockrell files for president-elect

David A. Cockrell, O.D., has filed for election to the position of president-elect of the AOA.

"It is a privilege and honor to have the opportunity to continue to serve our profession," Dr. Cockrell said.

Currently, Dr. Cockrell serves as the liaison trustee to the Advocacy Group Executive Committee, Federal Legislative Action Keyperson Committee, Federal Relations Committee, Health Center Committee, State Government Relations Committee, and Third Party Center Executive Committee.

During his time as an AOA volunteer, Dr. Cockrell has served as chair of the following committees: AOA State Government Relations Center, Patient Care and Management, the Primary Care and Patient Management, Statutory SCOPE, Nominating, and Resolutions and has served on the Federal Government Relations Committee and Legislative Action Response Committee.

He also chaired the first Affiliate Legislative Defense Fund Project Team.

He has served on the Information & Member Services Group, the Paraoptometric Section, the Contact Lens Section (charter member), and the Optometry's Meeting® New Practitioner Practice Management Project Team. He served on the board of directors of Optometry Cares®— The AOA Foundation.

A member of the Oklahoma State Board of Examiners since 1996, he has served as president and currently serves as a member of the board. Dr. Cockrell was the founding chair of the American Board of Optometry (ABO) and is a Diplomate of the ABO. Dr. Cockrell is a past president of the Oklahoma Association of Optometric Physicians (OAOP) and was named the OAOP OD of the Year in 1994.

He was named to the OAOP Optometry Team of the Century 2000 and chaired the OAOP Congress Committee, the Oral Pharmaceutical Legislative Committee, and the Laser

Legislative Committee. He is a fellow of the American Academy of Optometry.

A graduate of the Southern College of Optometry, Dr. Cockrell has volunteered with the Boy Scouts of America and is active with the Rotary Club, Group Homes for the Mentally Handicapped, the Public Education Foundation, the Chamber of Commerce, and the Regional Airport Authority.

Dr. Cockrell lives in Stillwater and practices with his wife Cherry B. Cockrell, O.D., Jeff D. Miller, O.D., and John M. Millirons, O.D.

The Cockrells have two children, Cherry Beth and Shepard.

Jump-starting your ICD-10 transition in 2013

The ICD-10 implementation deadline, Oct. 1, 2014, is a long way away. It's still a good time to begin planning for the changes though. Here are some things the doctors and staff in your practice can do now to ease the transition in 2014:

- Review ICD-10 resources from the Centers for Medicare & Medicaid Services (CMS) and other insurers.
- Be sure all doctors and staff in your practice know about the upcoming changes.
- Create an ICD-10 project management team for your practice, including doctors and staff.
- Begin to discuss how ICD-10 will affect your practice.
- Start working on an ICD-10 project plan for your organization, including scheduling staff training for choosing ICD-10 codes for diagnosis codes common to your practice.
- Ask your payers and vendors (software/systems, clearinghouses, billing services) about ICD-10 readiness and review contracts/proposals.
    - Ask about systems changes, timelines, costs, and testing plans.
    - Ask when they will start testing, how long they will need, and what they suggest your office should be doing to smooth the transition to ICD-10.
    - Select/retain vendor(s).
- Review changes in clinical documentation requirements and educate staff by using Internet-based programs for converting commonly used ICD-9 codes to ICD-10.

Each health care practice is unique, so your ICD-10 implementation plan will be unique too. You still have plenty of time to get ready, which makes this an excellent time to do a little research, identify resources for ICD-10 information, and begin using staff meetings to gradually raise awareness of the required changes in diagnosis coding. Watch *AOA News* and other AOA and AOAExcel™ communications for more on this very important subject.

Hawthorne files for re-election

Hilary L. Hawthorne, O.D., has filed for re-election to the AOA Board of Trustees.

Dr. Hawthorne was officially appointed to the AOA volunteer structure in 2006. She has been active in committees including the AOA Communications Advisory Group and served as chair of the Credentials Committee and the Hispanic Communications Project Team from 2008-2009.

"Building the AOA's relationships with key media stakeholders is essential to educating the public about our role as primary eye care doctors," Dr. Hawthorne said.

In 2007, she served as the AOA's spokesperson in promotion of the American Eye-Q® survey and has done numerous media interviews on behalf of the profession. Most recently, Dr. Hawthorne conducted desk-side media interviews in New York, N.Y., to promote optometry to consumers sthrough media channels such as *Parents, Family Circle, Real Simple, Fitness, Reader's Digest* and the *Wall Street Journal*.

Currently, Dr. Hawthorne serves as the liaison trustee to the Clinical Resources Group Executive Committee, Commission on Ophthalmic Standards, Ethics and Values Committee, Evidence-Based Optometry Committee, Health Promotions Committee, InfantSEE® Committee, New Technology E-Committee, OD Registries Committee, VISION USA Committee, and Sports Vision Section. She also functions as an observer liaison of the Third Party Center Executive Committee. Previously, she had served as liaison trustee to the Communications Group Executive Committee, the Hispanic Communication Project Team, Optometry's Image Coordinating Committee, Social Media Committee, Contact Lens and Cornea Section, Paraoptometric Executive Committee, Council on Research, and the Optometric Extension Program.

Dr. Hawthorne is a past president of the California Optometric Association (COA). She has been involved with many aspects of the COA, including the Public Vision League, the Vision West Advisory Board, Communications Committee, and the Education Committee. In 2013, Dr. Hawthorne remains involved as a COA volunteer serving as chair of the Nominating Committee, a member of the Legislation and Regulation Committee, the California Optometry Editorial Board, and as an education consultant for local society meetings. She presided as Speaker of the House to the 2012 COA House of Delegates (HOD) and chaired the HOD Advisory/Rules Committee. Over a decade ago, she served as a member-at-large on the COA Nominating Committee.

Dr. Hawthorne became a trustee for the Great Western Council of Optometry (GWCO), representing California from 2006-2010. She was recognized as the COA's Young Optometrist of the Year in 2000 and as Keyperson of the Year in 2001. She is a graduate of Pacific University College of Optometry.

Dr. Hawthorne remains active in her community and the Los Angeles County Optometric Society, providing resources for nearby schools, and has contributed service to California Vision Foundation and California Volunteer Optometric Services to Humanity. She is a member of the American Public Health Association, Vision Care Section. She has a private practice in south Los Angeles, Calif., and has worked as a staff doctor for the Los Angeles Unified School District's Student Medical Services.

AOA Next Generation Optometry
eXcel™

2013 EHR and Medical Records Compliance Program

AOAExcel™ supports practicing optometrists in the implementation and use of Electronic Health Records (EHRs).

These full-day programs will cover topics such as:

- The value of EHR when selling a practice
- Interoperability within the healthcare system
- Electronic image management and connectivity
- Stage II meaningful use criteria
- How to develop a Medical Records Compliance Program

Locations	Dates
Seattle, Washington	April 17, 2013
Washington, DC	April 19, 2013
San Diego, CA*	June 29, 2013
Atlanta, GA	August 21, 2013
Dallas, TX	August 23, 2013
Chicago, IL	November 6, 2013
Las Vegas, NV	November 8, 2013

*4-hour mini EHR Program at Optometry's Meeting® 2013

AOA members will receive $75 off the cost of their registration fee.

For more information, registration, and on-sale dates, please visit **ExcelOD.com/EHR**.

Audits,

from page 7

the criteria. Should an EHR system not be able to produce such a report, practitioners need to be prepared to provide paper records or worksheets.

Certification Criteria

Access control

Assign a unique name and/or number for identifying and tracking user identity and establish controls that permit only authorized users to access electronic health information.

Emergency access

Permit authorized users (who are authorized for emergency situations) to access electronic health information during an emergency.

Automatic log-off

Terminate an electronic session after a predetermined time of inactivity.

Audit log

(1) Record actions—Record actions related to electronic health information.

(2) Generate audit log—Enable a user to generate an audit log for a specific time period and to sort entries in the audit log according to any of the elements specified in federal standards.

Integrity

(1) Create a message digest.

(2) Verify in accordance upon receipt of electronically exchanged health information that such information has not been altered.

(3) Detection—Detect the alteration of audit logs.

Authentication

Verify that a person or entity seeking access to electronic health information is the one claimed and is authorized to access such information.

General encryption

Encrypt and decrypt electronic health information.

Encryption when exchanging electronic health information

Encrypt and decrypt electronic health information when exchanged.

Accounting of disclosures (optional)

Record disclosures made for treatment, payment, and health care operations.

Standards Criteria

Record actions related to electronic health information

The date, time, patient identification, and user identification must be recorded when electronic health information is created, modified, accessed, or deleted; and an indication of which actions(s) occurred and by whom must also be recorded.

Verification that electronic health information has not been altered in transit

A hashing algorithm with a security strength equal to or greater than Secure Hash Algorithm (SHA-1), as specified by the National Institute of Standards and Technology (NIST), must be used to verify that electronic health information has not been altered.

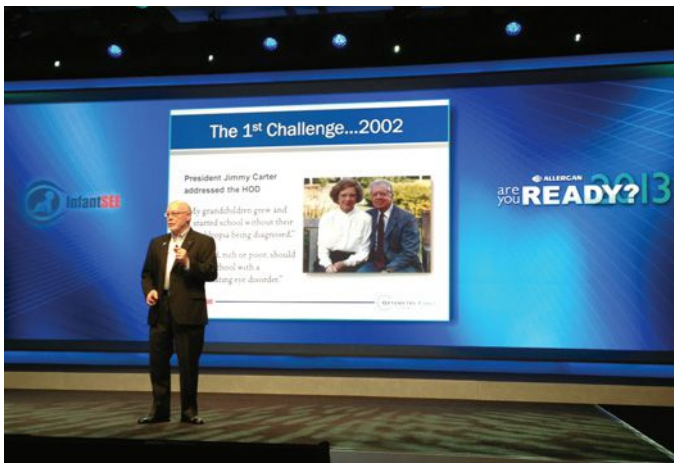
Encryption and decryption of electronic health information

Any encryption algorithm identified by the National Institute of Standards and Technology (NIST) should be used for any encrypted and integrity protected link.

Record treatment, payment, and health care operations disclosures

The date, time, patient identification, user identification, and a description of the disclosure must be recorded for disclosures for treatment, payment, and health care operations.

For additional information see "Eligible Professional Meaningful Use Core Measures: Protect Electronic Health Information" at *http://tinyurl.com/EHRMeasure15*.



AOA InfantSEE® Committee Chair Glen Steele, O.D., speaks about the importance of the program at the Annual Allergan National Sales Meeting in Orlando, Fla., Jan. 29. InfantSEE®, a public health program managed by Optometry Cares® -The AOA Foundation is designed to ensure that eye and vision care becomes an integral part of infant wellness care to improve a child's quality of life.

Internet,

from page 1

AOA and other eye health organizations are raising serious concerns about the safety and quality of prescription eyewear available online.

A joint study by a panel of eye care and eyewear industry experts representing the AOA, The Vision Council, and the Optical Laboratories Association, published in September 2011, "Safety and compliance of prescription spectacles ordered by the public via the Internet," found half of all eyeglasses prescriptions dispensed through online services are filled incorrectly (read more at *http://bit.ly/xt6ILj*).

VSP press releases say Eyeconic will help practitioners both retain and attract patients by allowing them to shop for eyewear at their leisure and select from a larger array of frames than might be offered in many practice dispensaries, at potentially lower prices.

"However, Eyeconic will be marketed to VSP enrollees, most of whom already have ongoing relationships with eye care providers," said Dr. Cockrell. "By encouraging patients to move toward the Internet as a primary source of eyewear products and information, the service will undermine traditional patient-practitioner relationships, reducing the likelihood that patients will undergo periodic eye examinations or seek necessary follow-up care for diagnosed eye conditions and ultimately proving detrimental to both patient care and traditional vision care practice."

"Chances for suboptimal correction will increase because patients will be placed in the position of having to recognize the frames that are best for correction of their vision problems, without the assistance of an eye care professional or trained dispensary personnel," Dr. Cockrell said. "Unlike other online eyewear retailers, Eyeconic will provide prescribing practitioners a share of the revenues from sales to their patients, but that will basically amount to a 'dispensing fee.'"

In return for that fee, practitioners will be required to take responsibility for the most problematic aspects of dispensing, he contends. "That means when problems occur, the optometrist and dispensary staff will be left to fix them – and take the blame for them," Dr. Cockrell said.

PQRS,

from page 8

Glaucoma Measures #12 and #141(age 18 and up)			
	With Optic Nerve View	Without Optic Nerve View (medical)	Without Optic Nerve View (no reason)
Controlled IOP	3284F + 2027F	3284D + 2027F-1P	3284F + 2027F-8P
Uncontrolled IOP +Care Plan	3285F + 0517F + 2027F	3285F+0517F+2027F-1P	3285F+0517F + 2027F-8P
No IOP measured	3284F-8P + 2027F	3284F-8P +2027F-1P	3285F+0517F + 2027F-8P
Uncontrolled IOP & no plan of care	3285F + 0517F-8P +2027F	3285F+0517F-8P+2027F-1P	3285F+0517F-8P+2027F-8P

Ongoing Diabetes Care

- Measure 117 – Diabetes Mellitus: Dilated Eye Exam in Diabetic Patient
- Measure 140 – Age-Related Macular Degeneration (AMD): Counseling on Antioxidant Supplement
- Measure 141 – Primary Open-Angle Glaucoma (POAG): Reduction of Intraocular Pressure (IOP) by 15 percent OR Documentation of a Plan of Care

(Measure numbers refer to the order of the measures listed in the original CMS documents and are not meant to be used to report the measures.)

The other four PQRS codes are registry-only codes and are not really meant for use by optometry.

The retained codes are cataracts codes for surgeons (#191 and #192).

The new PQRS codes are cataract outcomes by patient report (#303 and #304).

Details of the PQRS 2012 codes specific to eye care by disease

Again, all of the eye care-specific PQRS measures are applied when the provider is coding an evaluation and management code (99201-99205, 99212-99215) or a general ophthalmologic visit code (92002-92014). The evaluation and management codes for nursing home, rest home and others are also included.

Please see the box for a complete listing. The PQRS measures do not apply to any special ophthalmic service codes such as scanning laser, visual fields, and photography.

Macular Degeneration:

There are two measures for the diagnosis of macular degeneration. If any of the following three AMD diagnoses are coded, the provider may use one or both of these measures. As well, the patient needs to be 50 or older.

– 362.50 Macular Degeneration, NOS
– 362.51 Macular Degeneration, non-exudative
– 362.52 Macular Degeneration, exudative

Measure #14, using the QDC 2019F, indicates the provider had a dilated view of macula AND documented whether macular thickening and hemorrhages were present or not present.

The provider must dilate and record finding, once per 12-month period or once per reporting period.

However, the QDC must be used on every claim submitted for the AMD diagnosis even when the dilated macular examination was performed during a prior patient visit.

The exceptions for 2019F are:
1P: medical reason for no dilated macula view
2P: patient reason for no dilated macula view
8P: other reason for no dilated macula view

One of these exceptions would be used only if the provider could not complete the measure requirements for the reason attached to the exception. The exception is indicated using the 1P, 2P or 8P as a modifier to the QDC.

Measure #140, using the QDC 4177F, indicates that the provider discussed the pros and cons of Age-Related Eye Disease Study (AREDS) formulation of antioxidant supplements and made proper recommendations for individual and documented discussion per the AREDS report.

For more information, see *www.aoa.org/PQRS*.

This discussion and documentations must occur once per 12-month period or once per reporting period for each unique patient. However, the QDC must be used on every claim submitted for the AMD diagnosis even when the AREDS discussion occurred during a prior patient visit.

The only exception for 4177F is 8P: no reason for not discussing AREDS.

Primary Open-Angle Glaucoma:

There are two measures for the diagnosis of glaucoma. If any of the following glaucoma diagnoses are coded, the provider may use one or both of these measures. As well, the patient needs to be 18 or older.

– 365.10 Open-Angle Glaucoma, unspecified
– 365.11 Primary Open-Angle Glaucoma
– 365.12 Low-Tension Glaucoma
– 365.15 Residual Open-Angle Glaucoma

Please note codes 365.70-365.74 were deleted from this measure for 2013.

Measure #12, using the QDC 2027F indicates the provider viewed optic nerve with or without dilation. The provider must document the results of the optic nerve view once per 12-month period or once per reporting period for each unique patient. However, the QDC must be used on every claim submitted for the glaucoma diagnosis, even when the optic nerve view occurred during a prior patient visit.

The exceptions for 2027F are:
1P medical reason for not viewing optic nerve
8P no reason for not viewing optic nerve

Measure #141 has three different codes to consider with several different code combinations. QDC 3284F is used to indicate when the IOP is reduced 15 percent or more from pre-intervention levels. QDC 3285F is used when IOP is NOT reduced 15 percent from pre-intervention levels and 0517F is added to indicate that a plan of care to get IOP reduced is in place.

The exceptions would be as follows:
3284F: 8P IOP not documented, no reason given
3285F: No exceptions because you would use 3284F- 8P if the IOP was not measured.
0517F: 8P no plan of care documented to reduce the IOP

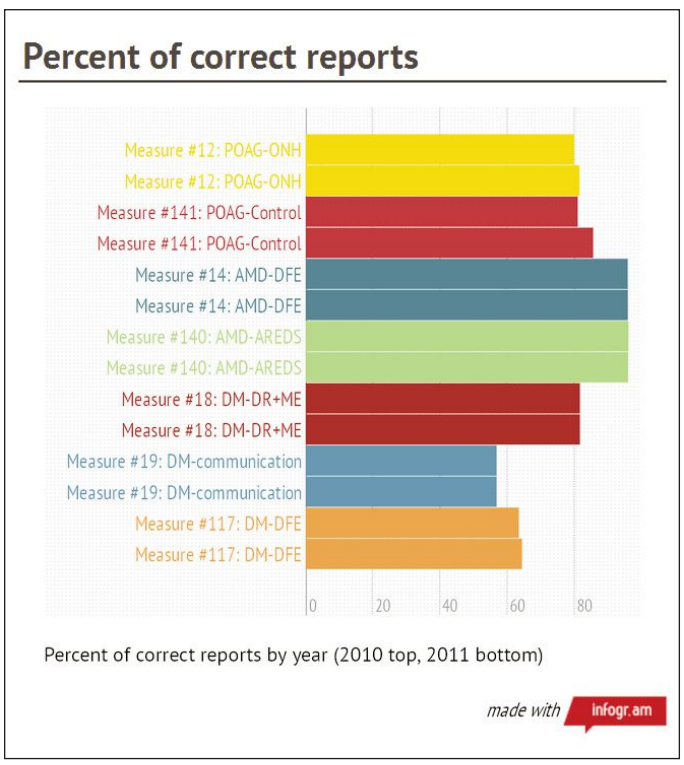
For QDC 0517F, a plan of care might consist of a plan to recheck of IOP at specified time, a change in therapy, a plan to perform additional diagnostic evaluations, monitoring of IOP per patient decisions, indication that the target IOP was unable to be achieved due to health system reasons or a referral to a specialist. Again, any plan of care should be documented in the patient record. See glaucoma summary chart.

Diabetes

Three different measures are in place for a patient with diabetes, either insulin dependent or non-insulin dependent that include measure #18, #19 and #117. See the summary for all the combinations possible.

Measure #18 and #19, using the QDC 2021F, 5010F and G8397 or G8398, are used only with diabetes when retinopathy is present. The provider must perform a dilated macular or fundus examination and document the pres-

See PQRS, next page



PQRS,

from page 13

ence or absence of macular edema and the level of diabetic retinopathy.

This measure is never used when there is no diabetic macular edema or diabetic retinopathy. The patient must be 18 or older.

The following diabetic retinopathy diagnoses are the only ones applicable to this measure:

– 362.01 Background Diabetic Retinopathy
– 362.02 Proliferative Diabetic Retinopathy
– 362.03 Nonproliferative Diabetic Retinopathy, not otherwise specified
– 362.04 Mild Nonproliferative Diabetic Retinopathy
– 362.05 Moderate Nonproliferative Diabetic Retinopathy
– 362.06 Severe Nonproliferative Diabetic Retinopathy

Diabetic macular edema

Please note 362.07-Diabetic macular edema is not one of the listed codes. The proper coding for macular edema is to report the systemic diabetic diagnosis then the proper diabetic retinopathy diagnosis and finally the diabetic macular edema diagnosis.

Only link this measure to the applicable diabetic retinopathy codes. Do not link 2021F to the systemic diabetic diagnosis or to the macular edema diagnosis.

The exceptions for 2021F are as follows:
1P medical reason for not documenting macular edema and diabetic retinopathy
2P patient reason for not documenting macular edema and diabetic retinopathy
8P no reason for not documenting macular edema and diabetic retinopathy

Measure #19 uses three different QDCs. 5010F indicates the provider has communicated the presence or absence of macular edema and the level of diabetic retinopathy to the physician responsible for the diabetic care. Again, the same list of diabetic retinopathy diagnoses listed for measure #18 applies to this measure. Again the patient age range is anyone 18 or older for this measure.

In addition, the provider needs to indicate if a dilated macular or fundus examination was performed. The QDC options for this information are G8397, indicating the dilated macular or fundus exam was performed, or G8398, indicating the dilated macular or fundus exam was not performed.

There are no exceptions for G8397 and G8398, but the exceptions for 5010F are:
1P medical reason for not communicating
2P patient reason for not communicating
8P no reason for not communicating

Dilated diabetic exam

Measure #117 uses one of four QDCs to indicate a Dilated Diabetic Examination was performed. This measure is only used for patients 18 to 75. And this measure is used for an expanded list of diagnoses. Any of these diabetes diagnoses apply to this measure:
250.00-250.03, 250.10-250.13, 250.20-250.23, 250.30-250.33, 250.40-250.43, **250.50-250.53**, 250.60-250.63, 250.70-250.73, 250.80-250.83, 250.90-250.93, 357.2, **362.01-362.07**, 366.41, 648.01-648.04

The bolded diagnoses are the more common ones used by eye care providers. Remember to link the QDC to only one diagnosis code.

The provider would use one of the following QDCs to report this measure. QDC 2022F is used to indicate a dilated eye exam was performed in a diabetic patient by an optometrist or ophthalmologist. QDC 3072F would be used when the patient is at low risk for diabetic retinopathy (meaning that patient had a normal examination without diabetic retinopathy within the last year).

Imaging codes

Two other codes for imaging views of the retina exist for this measure, but are not commonly used by eye care providers. QDC 2024F would be used for reporting that seven standard field stereoscopic photos with interpretation by an ophthalmologist or optometrist were documented and reviewed. QDC 2026F would be used to indicate eye imaging was validated to match the diagnosis from seven standard field stereoscopic photos results and were documented and reviewed. Because most optometrists perform dilated diabetic examinations, 2022F would be the most common QDC used to report this measure.

Disease first

When thinking about the seven QDC measures applicable for eye care providers, it is helpful to consider these measures by disease.

For example, when seeing a patient with AMD who is 50 or older, a provider would typically perform a dilated macular examination at least yearly and discuss the AREDS formulation of supplements at least yearly. Thus, the provider could easily code 2019F and 41277F together for all the AMD patients each and every time this AMD diagnosis is coded and sent to Medicare.

Consistency is the key to participating and earning the bonus payments for PQRS. And it is essential in avoiding future penalties if a provider does not participate.

Similarly, with a glaucoma patient who is 18 years of age or older, the provider typically would perform an optic nerve evaluation at least yearly and would measure the intraocular pressure at least yearly.

In addition, when the IOP is not controlled, a provider would typically develop a plan to reduce the IOP to an acceptable level.

Coding 2027F and 3284F for a controlled glaucoma patient or 2027F, 0517F and 3285F together for an uncontrolled glaucoma patient would not be difficult.

Diabetic patients present a little more challenge in properly applying the PQRS measures.

Age is a key to properly applying these measures. Any diabetic patient, with or without diabetic retinopathy, between 18 and 75 years would have the QDC of 2022F coded to indicate a dilated eye examination was performed (assuming that the provider would typically dilate all diabetic patients yearly).

In addition, when diabetic retinopathy (with or without macular edema) is found, the provider would use 2021F to indicate a dilated macular or fundus examination was performed.

Use 5010F to indicate a report was sent to the provider caring for the diabetes along with G8397 to again indicate the dilated macular or fundus examination was performed. However, the age for these measures is 18 and older.

Please note it is best practice for an eye care provider to communicate with all physicians caring for patients with diabetes, but PQRS only addresses this report when diabetic retinopathy and/or macular edema are found.

And note any and all exceptions to the examples above for all the measures would be reported using the appropriate modifiers listed earlier in this article.

PQRS is not difficult. Consistency is the key to participating and earning the bonus payments and avoiding the penalties that will come in the future if a provider does not participate.

Providers should use the summary sheet developed by the AOA when seeing patients and coding the examinations to make the process easier (*www.aoa.org/x17508.xml*).

Additional information on the PQRS program can be found at *www.excelod.com*.

Happy Coding…

Diabetes Summary Chart Measure #18, #19, #117

	Age 18-75	Over Age 75
DM+ DFE-No retinopathy (DR)	2022F	No code
DM+No DFE-No DR	2022F-8P	No code
DM+DFE+DR +communication	2022F +2021F+5010F+G8297	2021F+5010F+G8397
DM+DFE+DR+no comm (medical)	2022F+2021F+G8397+5010F-1P	2021F+G8397+5010F-1P
DM+DFE+DR+no comm. (patient)	2022F+2021F+G8397+5010F-2P	2021F+G8397+5010F-2P
DM+DFE+DR+no comm.(no reason)	2022F+2021F+G8397+5010F-8P	2021F+G8397+5010F-8P
DM+No DFE+DR+no comm.(medical)	2022F-8P+2021F-1P+G8398+5010F-8P	2021F-1P+G8398+5010F-8P
DM+No DFE+DR+no comm.(patient)	2022F-8P+2021F-2P+G8398+5010F-8P	2021F-2P+G8398+5010F-8P
DM+No DFE+DR+no comm. (no reason)	2022F-8P+2021F-8P+G8398+5010F-8P	2021F-8P+G8398+5010F-8P

CMS issues 'sunshine rule' on industry-practitioner relationships

The Centers for Medicare & Medicaid Services (CMS) announced Feb. 1, 2013, a new rule designed to increase public awareness of any financial relationships existing between drug or medical device manufacturers and health care providers.

The "National Physician Payment Transparency Program: Open Payments" initiative is one of several measures authorized under the Affordable Care Act (ACA) to encourage greater transparency in the health care market, according to the CMS.

The new "sunshine rule" finalizes ACA provisions that require manufacturers of drugs, devices, biologicals, and medical supplies covered by Medicare, Medicaid, or the federal Children's Health Insurance Program (CHIP) to report payments or other transfers of value they make to physicians and teaching hospitals to the CMS.

The CMS then will post that data to a public website.

The AOA Ethics and Value Committee is studying the new rule and plans to issue a "white paper" on the new reporting program before it takes effect late this summer.

In addition to manufacturers, the rule will apply to group purchasing organizations (GPOs), which the CMS emphasizes will have to disclose physician ownership or investment interests.

The new reporting program is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers.

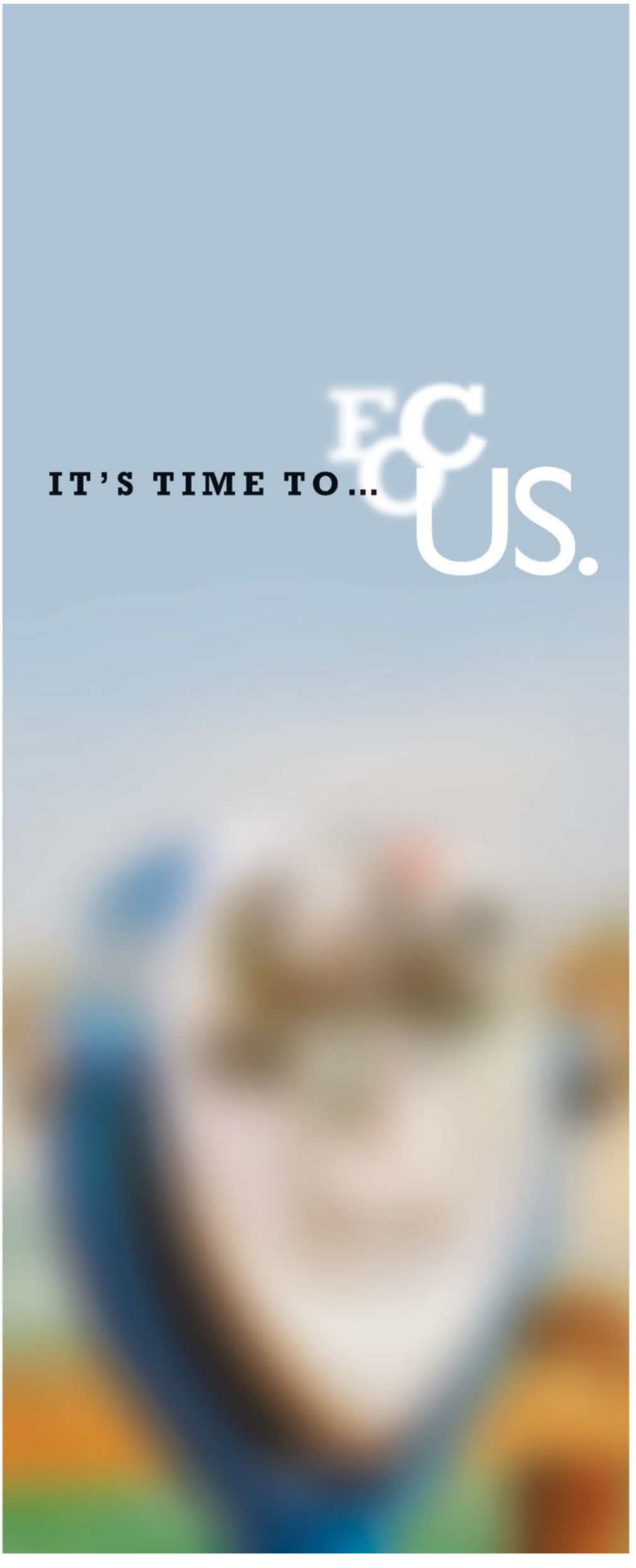
"You should know when your doctor has a financial relationship with the companies that manufacture or supply the medicines or medical devices you may need," said Peter Budetti, M.D., CMS deputy administrator for Program Integrity. "Disclosure of these relationships allows patients to have more informed discussions with their doctors."

The new reporting program is intended to help reduce the potential for conflicts of interest that physicians or teaching hospitals could face as a result of their relationships with manufacturers.

Manufacturers and GPOs, as well as the physicians and teaching hospitals, will have an opportunity to review and correct reported information prior to its publication.

In order to give applicable manufacturers and applicable GPOs sufficient time to prepare, data collection will begin Aug. 1, 2013. Applicable manufacturers and GPOs will report the data for August through December 2013 to the CMS by March 31, 2014, and the CMS will release the data on a public website by Sept. 30, 2014.

The CMS is developing an electronic system to facilitate the reporting process. The final rule can be downloaded at *https://www.federalregister.gov/public-inspection*.



Attendees can FOCUS on education at Optometry's Meeting® in San Diego!

FOCUS. Looking to Tomorrow…Together is the 2013 theme for Optometry's Meeting®. In that spirit, the AOA put together an outstanding lineup of speakers and exciting new specialty tracks that explore and demonstrate effective collaboration.

With the new inclusive registration fee, you don't have to choose your continuing education (CE) sessions in advance. Instead, you can decide what you'd like to attend on-site.

Remember seating inside courses will be available on a first-come, first-served basis so be sure to arrive at your CE sessions early!

Customized learning

Experience in-depth, diverse programming and take advantage of learner-centered education.

Gain the practical pearls you need to stay advanced and competitive in the industry and make your practice more profitable.

Optometry's Meeting® 2013 offers more chances to delve deep into a topic with the expansion of specialty-focused tracks.

Customize your education schedule based on your learning needs and interests.

Specialty tracks include:

- Glaucoma – Presented in partnership with the Optometric Glaucoma Society
- Ocular Nutrition – Presented in partnership with the Ocular Nutrition Society
- Ocular Surface – Presented in partnership with the Ocular Surface Society of Optometry
- Refractive Technology – Presented in partnership with the Optometric Council on Refractive Technology
- Retina – Presented in partnership with the Optometric Retina Society
- Vision Development – Presented in Partnership with the College of Optometrists in Vision Development
- Rapid-Fire – If you're a fan of the rapid-fire question-and-answer format familiar from sports TV shows, you won't want to miss our Pardon the Objection (PTO) courses. Instead of lectures, you'll get a panel discussion and debate on a new topic every few minutes — with a graphic "rundown" of yet-to-be-discussed topics just like you see on TV.

Seven courses will be presented in this unique style on topics such as anterior segment; contact lenses; glaucoma diagnostic and technology review; glaucoma treatment/ medication/ surgery; and posterior segment.

Gain the practical pearls you need to stay advanced and competitive in the industry and make your practice more profitable.

Interactive courses

Back by popular demand, Optometry's Meeting® will once again present interactive sessions on multiple topics, allowing audience members to participate in real time.

In select sessions you can ask panelists questions, suggest discussion topics, and take real-time surveys by texting — all promising to make these sessions exceptionally relevant.

Within walking distance of the San Diego Convention Center is Seaport Village. It's home to more than 70 shops and restaurants located right on the waterfront.
Photo courtesy of Joanne DiBona, SDCVB

Learn and eat

Also back by popular demand, our Breakfast Sessions will be held on Thursday and Friday featuring a variety of topics.

See the Preliminary Program available at *www.optometrysmeeting.org* to get more details on times and subjects.

Practice makes perfect

If you are looking to buy, buy-in or sell a practice, our two-part Practice Pathways course is tailor-made for your needs.

You'll discover how to be successful in each stage of the practice lifecycle, including practice entry, practice management, development planning and succession planning.

All attendees can attend the Practice Pathways course at no additional charge.

CPR/AED for health professionals

You asked, we listened. Two CPR/AED for Health Care Provider classes will be held Thursday.

There is an additional fee for this specialty course, and the American Red Cross Certification is included.

Informal learning

The Scientific Poster Session provides informal opportunities for optometric professionals to present data and conduct extended discussions of their research with interested colleagues, using illustrative wall displays.

Scientific poster sessions will take place Saturday afternoon.

New this year you can also check out the posters on your mobile device using the Optometry's Meeting® app.

Education at your fingertips

The Optometry's Meeting® Mobile App is now available for download on your iPhone, Android or Blackberry devices. You can use it to create your schedule, search events by function or speaker, and stay up to date on the latest conference happenings — making your conference experience better than ever.

At Optometry's Meeting® 2013, one low price includes your continuing education sessions, admittance to the Exhibit Hall, the Welcome Reception, Opening General Session, Varilux® Optometry Student Bowl™, and the Celebration of Optometry (Presidential Celebration). What a great value!

Visit *www.optometrysmeeting.org* for the full schedule of events, conference highlights and the endless list of more than 200 hours of continuing education courses.

Optometry's meeting®

American Optometric Association

AOSA American Optometric Student Association

ON SAN DIEGO!

Optometry's meeting®

JUNE 26–30, 2013

Early-Bird Registration is now open!

Don't miss your opportunity to beat the rush, secure your preferred hotel, and begin planning what will be an unforgettable Optometry's Meeting®. From over 50 targeted networking opportunities to enhancements such as an Inclusive Registration Fee and the first Optometry Cares® 5K Run/Walk, the early bird can catch more than ever in 2013!

Register today at optometrysmeeting.org

Looking to tomorrow… ***Together.***

Health insurance marketplaces (exchanges):
What optometrists need to know as small business owners

Many optometrists may be concerned about their role and responsibilities as small business owners in the formation of health insurance exchanges. The Affordable Care Act (ACA) mandated the development of health insurance exchanges, also known as "marketplaces." A health insurance marketplace is a place where consumers and small business owners can go to purchase health care insurance. Starting in 2014, these marketplaces will be accessible through a variety of means, including the Internet, call centers, agents and brokers, in person, or by mail. There has been much discussion and misinformation circulated regarding the responsibilities of small business owners with regard to providing health insurance coverage to employees both inside and outside of the health insurance marketplaces. The frequently asked questions below provide the information you need to know now.

As an optometrist and a small business owner, where can I go to look at health insurance coverage options for my employees?

Beginning in 2014, Small Business Health Options Programs (SHOP) – insurance purchasing cooperatives within the marketplaces – will be available to small business owners in each state. Through the SHOP marketplaces, employers can review coverage options and provide their employees with qualified health plans (QHPs) to choose from for health insurance coverage. Insurance options and information is also currently available at *http://finder.healthcare.gov*.

What sorts of benefits will health plans offer in the SHOP marketplaces?

All small group and individual health plans will cover essential health benefits in the new exchange marketplaces or in the traditional open market that remains. Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

The AOA successfully worked with Congress to ensure pediatric vision coverage is considered an essential health benefit in all individual and small group plans, inside and outside the health insurance exchanges. For additional information, see *www.healthcare.gov/glossary/e/essential.html*.

How do I access the SHOP marketplaces?

The SHOP marketplaces are still under development. Each state has had the option of choosing to create a fully state-based insurance marketplace, develop an exchange working with the federal government, or, if a state is not willing or able to develop an exchange, the federal government will develop and operate the exchange on behalf of the state. So far, 18 states have opted to establish their state-based insurance marketplaces. Other states are expected to announce their plans before the end of March. For more information on the direction of your particular state, visit *http://tinyurl.com/65y23ny* or *http://tinyurl.com/b69w2pm*.

I offer health insurance coverage to my employees now, and I'd be interested in using the SHOP marketplace in the future. When can I start?

The open enrollment period for the insurance marketplaces will begin Oct. 1, 2013.

If I currently use an insurance broker to help me purchase insurance for my employees, do I need to continue to use the broker when using the SHOP insurance marketplace?

You are not required to use an insurance broker. If you would like to continue to use a broker you may, but you are also able to purchase insurance independently.

If my employees choose different plans from the options available to them in the SHOP will I be required to make separate payments to all the different plans?

No. You will be able to make a single monthly payment to SHOP.

I don't currently offer insurance to my employees but I would like to in the future if it is financially feasible. What do I need to know?

The ACA includes some provisions to encourage small business owners to provide insurance coverage to employees. If you have up to 25 employees, pay average annual wages below $50,000 and cover at least 50 percent of the cost of health insurance coverage, you may qualify for a small business tax credit of up to 35 percent. This tax credit was included in the legislation in an attempt to offset the cost of insurance. The credit is supposed to increase to 50 percent in 2014.

The U.S. Department of Health & Human Services has also released some brief guidance regarding issues small business owners may wish to consider if using the SHOP marketplaces. That information is available at *http://tinyurl.com/b2nuqb4*.

As a small business owner am I required to use the SHOP marketplaces?

No, although at least one jurisdiction has proposed it. In all or nearly all states, you will be able to decide whether or not you would like to participate in SHOP insurance marketplaces. If you currently buy insurance from an insurance company, you can con-

See Marketplaces, next page

Industry begins offering CE for pain relievers in March

Health care practitioners, including optometrists, will receive the first offers of free, industry-sponsored continuing education (CE) in March as part of the U.S. Food and Drug Administration's (FDA) new Risk Evaluation and Mitigation Strategy (REMS) program to ensure the benefits of drugs or biological products outweigh any risks.

Under the REMS program, more than 20 manufactures of extended-release (ER) and long-acting (LA) opioids, such as Vicodin, Percodin, and Percoset, are expected to begin notifying health care practitioners of REMS CE opportunities.

Participation in the CE programs is optional for health care practitioners, the AOA Advocacy Group and AOA Clinical Resources Group noted.

While the FDA mandates drugmakers offer the CE courses, health care practitioners are not mandated to take them.

Participation in the CE courses is not required for practitioners who wish to prescribe the pharmaceuticals, the FDA confirmed. However, the CE could become mandatory in the future for health care practitioners who are registered with the U.S. Drug Enforcement Administration to prescribe controlled substances.

The new REMS program was authorized under the federal Food and Drug Administration Act of 2007 to combat increases in health problems or outright abuse associated with prescription pharmaceuticals.

An REMS Blueprint for prescriber education on ER and LA opioids was approved by the FDA in July 2012.

In most cases, REMS CE will be offered through established CE providers under grants from manufacturers. Drugmakers were to begin notifying prescribers of the new REM CE offerings March 1, 2013.

Consumer education campaigns will also directly help patients understand the risks of ER/LA opioids.

Since the REMS program was authorized, the FDA has developed risk mitigation initiatives for almost 70 drugs, most centering around medication guides and consumer education. The new initiative on ER/LA opioids is among the first to involve formal continuing education for prescribers.

For additional information on the FDA REMS program, visit *http://tinyurl.com/FDAREMS*. Information on the REMS ER/LA initiative can be found at *http://tinyurl.com/REMSERLAopioids* and *http://tinyurl.com/REMSERLAblueprint*.

Marketplaces,

from previous page

tinue to do so. It is important to note the small business tax credit for offering insurance coverage is only available if you purchase insurance through the exchange.

Will I be subject to penalties if I don't offer health insurance to my employees?

Penalties will only be assessed for employers who have more than 50 FTE employees. Employers that meet the size requirement and do not offer health benefits coverage will be required to pay a fine of $2,000 per year for each full-time employee, excluding the first 30 full-time employees. Additionally, employers with more than 50 FTEs that do offer health benefits coverage but the coverage is considered unaffordable may be assessed a fine of $3,000 per year for each full-time employee receiving federal financial assistance. This payment penalty cannot be greater than the penalty that would occur if the business did not offer health care coverage at all.

How many businesses are expected to incur financial penalties for failing to provide adequate health care coverage?

The HHS estimates less than 2 percent of large employers will be fined.

How is a FTE defined?

Full time is considered 30 or more hours per week. FTEs are calculated by summing the hours of full and part-time employees. As such, two half-time employees are equivalent to one full-time employee.

I have only three full-time-equivalent (FTE) employees in my optometric practice. Am I eligible to purchase insurance through the SHOP marketplace?

Yes, businesses with up to 100 employees will be eligible. However, until 2016 states may limit participation to businesses with only up to 50 employees. State departments of insurance can provide more information on participation thresholds.

I employ 10 FTE employees in my optometry practice. Will I be forced to pay a penalty if I don't offer those employees health insurance coverage?

No. Employers with fewer than 50 FTE employees will not incur any fines if the employer chooses not to offer health insurance coverage to employees.

I currently have more than 50 full-time employees but I am planning to downsize as I approach retirement. When will it be determined whether I have 50 or more full-time employees?

The U.S. Internal Revenue Service (IRS) has provided detailed guidance regarding when and how to determine the number of full-time employees a business has (*http://tinyurl.com/apulhem*). In essence, employers can choose either a six-month or 12-month period in 2013 to determine each employee's full-time status. An employer would review the six-month or 12-month period to determine whether the employee averaged at least 30 hours per week during the specified period that would make that employee a full-time employee.

If I have more than 50 employees can I reclassify some of them as consultants to avoid the requirement to provide insurance coverage?

An employment attorney should be consulted for assistance in classifying individuals you employ. It is also important to note the IRS performs audits to determine whether individuals have been inappropriately classified as consultants.

I don't offer health coverage to my employees and I don't plan to in the future. Do my employees have any options for purchasing coverage?

Yes. Your employees and their families will be eligible to purchase insurance coverage through the exchange.

Additional resources

AOA guidance and information for ODs: *www.aoa.org/reform*
General information: *www.healthcare.gov/small-business*
Tax information: *www.irs.gov/sbhtc*
Current coverage options: *finder.healthcare.gov*

NYSOA kids' program increases eye care awareness, highlights importance of children's sun protection with help of HEHP grant

Specifically targeting the five boroughs of New York City, the goal of New York State Optometric Association's "Kids Do Care for Eye Care!" program is to deliver comprehensive eye screenings for children and adolescents, determine undiagnosed vision problems, and emphasize the importance of ultraviolet (UV) sun protection. Participating organizations include various community centers in Spanish Harlem, Harlem and Brooklyn, and the State University of New York (SUNY) State College of Optometry.

Because UV exposure may increase the risk of retinal damage and cataract development, the "Kids Do Care for Eye Care!" program reinforces the importance of eye protection from the sun. Through the program, children are screened for early signs of sun damage to their eyes, and eyeglasses provided include photochromic polycarbonate lenses to protect against UV rays.

Thanks in part to a $4,000 Healthy Eyes Healthy People® (HEHP) grant received through the New York State Optometric Association (NYSOA), Program Director Joan K. Portello, O.D., has continued to expand her work with children in the community through the "Kids Do Care for Eye Care!" program, providing vision screenings, sun protection, and more.

Dr. Portello is a 26-year SUNY faculty member and a private practitioner for more than 23 years in Seaford, N.Y. Dr. Portello is also the director of Metro Games at the Special Olympics Lions Club Opening Eyes program. She is known for her many professional affiliations, awards, publications, and community service involvement.

"Many parents don't realize the importance of UV eye protection and sometimes take vision for granted."

In Spanish Harlem, the NYSOA got the word out as the program was presented as part of an annual event for children and families known as "free community health and fitness day."

Dr. Portello tracks children in need of follow-up vision care to ensure they receive necessary services. If comprehensive eye exams are needed, the grant allows children to receive full eye exams, eyewear and vision training.

"SUNY has been very gracious in providing optometry student volunteers to help with the program, sending mailings and using its website to announce program lectures throughout the year," Dr. Portello said. "Working with SUNY is a win-win, and the many student volunteers provide a wonderful learning experience for all."

Joan Portello, O.D., shows off third-graders at the Benjamin Altman School in Chinatown.

"To help reach low-income Asian-American children, we visited classes at the Chinatown elementary school," Dr. Portello said. "The principal of the school was very happy with the program, and we'll be scheduling another visit soon."

After the vision screening, if a child is in need of further vision care such as eyeglasses or vision therapy, an appointment is made for the child to be seen at SUNY, where an eye exam and eyeglasses are provided.

"Many parents don't realize the importance of UV eye protection and sometimes take vision for granted," Dr. Portello said. "With the help of many SUNY student volunteers, we deliver eye care and protection from ultraviolet (UV) rays to children where it's needed most."

The "Kids Do Care for Eye Care!" program is instrumental in the New York City area because while many children may already have state health insurance aid, parents may not seek eye care for their children. Also, parents may not realize the connection between good vision and academic performance.

The children's vision screening includes visual acuities cover tests, ocular motility assessment, pupil evaluation, direct ophthalmoscopy, retinoscopy, autorefraction, accommodative facility testing, non-contact tonometry, biomicroscopy, motor free visual perceptual test (MFVPT-3) and the Gardner reversal frequency test. Detailed consent forms explaining the tests are signed by parents or guardians prior to testing.

SUNY third-year student volunteer Jessica Scherer performs visual testing with a student.

SUNY volunteers performing test students' vision. "We use various shapes with the children to point out the connection between visual and conceptual because what a child sees through their eyes is processed in their brain, too," said Dr. Portello.

An added benefit for the children is the one-on-one attention they receive.

"It's great to see the children's faces light up during the screening," she said. "It's also important for them to know that someone cares – it's not just about school or learning – it's about their vision and overall health as well."

Congratulations to the New York State Optometric Association and Dr. Portello for receiving a HEHP grant that helped make the "Kids Do Care for Eye Care!" program possible.

Healthy Eyes Healthy People®

The AOA and Optometry Cares® – The AOA Foundation, through a generous grant from Luxottica, offer the Healthy Eyes Healthy People® state association grants. The grants provide funding for collaborative community programs involving optometrists with government agencies and health care advocates to address the U.S. Department of Health & Human Services (HHS) Healthy People objectives through a comprehensive approach to meeting the vision and eye health care needs of America's infants, children, adolescents, adults and seniors. For more information, visit *www.aoa.org/hehp*.

VISION USA pilot program to offer exams, lenses

Optometry Cares® – The AOA Foundation's VISION USA program, Lions Club International Foundation (LCIF), and Essilor of America will jointly establish a pilot program to correct uncorrected refractive error. The foundation recently finalized partnership discussions with the New Jersey Lions Glass Recycle Center (NJLERC) as part of the initiative.

The LCIF, in partnership with Essilor of America, trademarked a low-cost "Lion Lens" that NJLERC can now use along with new donated eyeglass frames or "Lions frames." For the first time, Lions will have access to quality low-cost lenses that may be used to fill prescriptions from licensed eye care professionals willing to donate free eye exams to poor, sight-impaired people in local communities.

In New Jersey, the pilot program will allow local Lions Clubs to refer those in need for a free eye examination by completing the VISION USA referral application. Patients meeting the financial criteria will be scheduled for appointments with volunteer VISION USA optometrists at no cost.

"I would like to thank Alcon and the foundation for the support in this project," said Max Ernst, O.D., VISION USA Committee chair. "VISION USA is very excited about the start of a new project with Alcon. VISION USA optometrists can help those college students who are in need of eye care and help further their education. Good vision is a requirement for learning at all levels of education, from kindergarten to college."

Optometry Cares® and the VISION USA committee hope to make the most of the existing VISION USA provider network but also need to expand provider recruitment across New Jersey.

The foundation is asking AOA member volunteers to provide a one-time comprehensive eye exam. This pilot project is geared to improve access to comprehensive vision and eye health care for New Jersey residents.

To assist in these efforts, visit *www.aoafoundation.org* or email *visionusa@aoa.org*.

Volunteers In Service In Our Nation - VISION USA - provides basic eye health and vision services free-of-charge to low-income, uninsured individuals and their families. VISION USA is provided by participating AOA member optometrists who donate their services to their local community. In 2012, VISION USA received more than 6,000 applications for assistance and has more than 3,000 participating optometrists serving as volunteers.

Optometry Cares® 5K Run/Walk

Stretch your legs and lungs at the Optometry Cares® 5K Run/Walk at the 2013 Optometry's Meeting® in beautiful San Diego, Calif. This timed 5K Run/Walk will take place Saturday, June 29. Registration is limited, so sign up soon! The registration link can be found at *www.aoafoundation.org* or *www.optometrysmeeting.org* and includes a technical race shirt, chip-timed bib and race packet.

Foundation calls for InfantSEE® Sullins award nominations

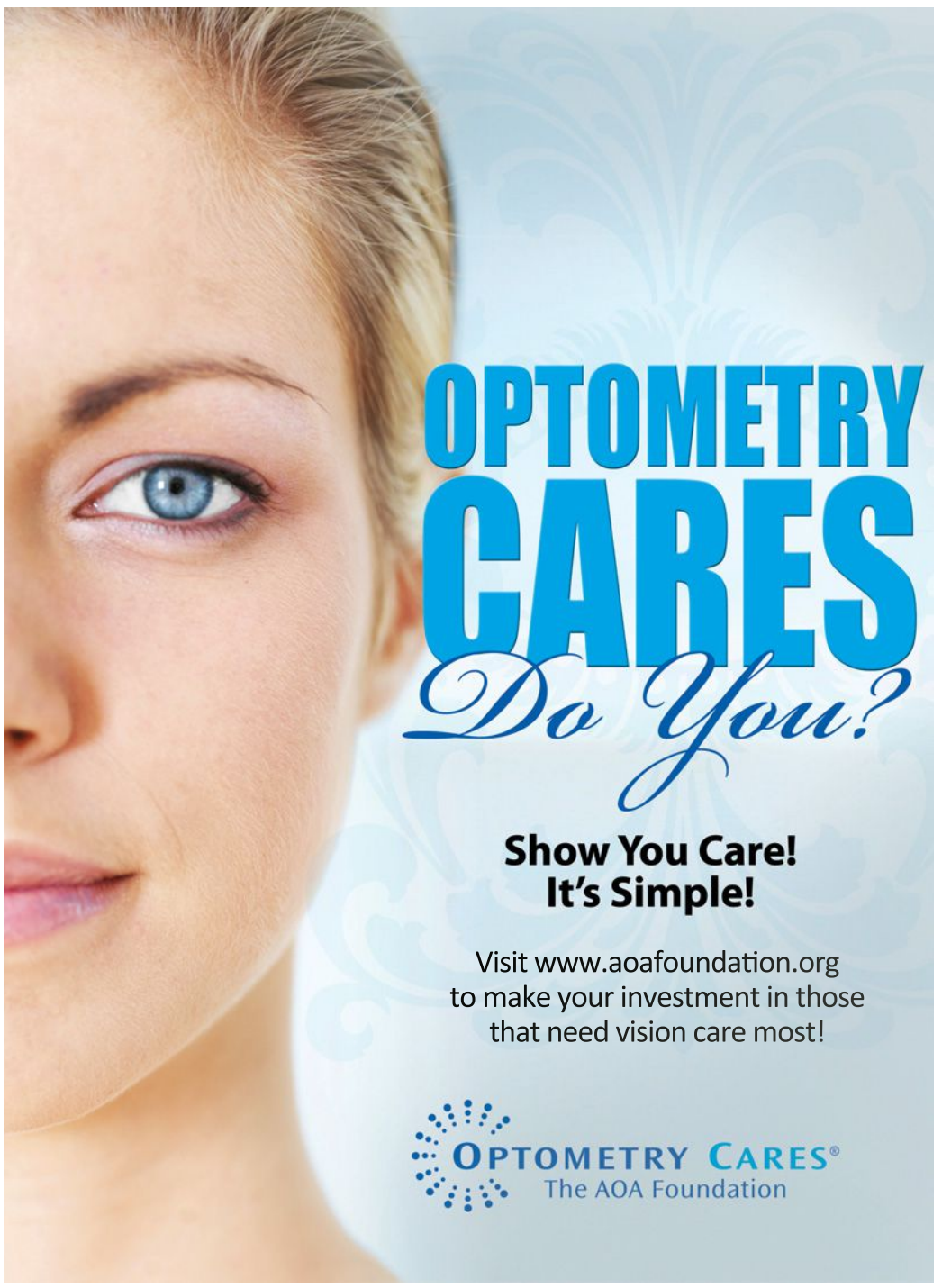
Optometry Cares® - The AOA Foundation and the InfantSEE® program invite the optometric community to submit nominations for the Dr. W. David Sullins, Jr. InfantSEE® Award. This award recognizes an individual doctor of optometry who has made significant contributions to optometry or his/her community for outstanding public service involving the InfantSEE® program.

The award will be presented at Optometry's Meeting® in San Diego this June. The recipient will receive travel reimbursement up to $1,000 and a gold medallion.

To nominate a colleague, visit Optometry Cares® – The AOA Foundation's website at *www.AOAFoundation.org*.

Nominations must be submitted online by April 30, 2013.

If you have questions about the application process, contact the AOA Foundation at *foundation@aoa.org* or at 800-365-2219, ext. 4209.



Longtime SUNY advocate Posner remembered

Champion of the State University of New York (SUNY) State College of Optometry and lifelong Westchester, N.Y., resident James Posner, O.D., died Oct. 23, 2012. He was 76.

After graduating from the University of Vermont, Dr. Posner attended the Pennsylvania College of Optometry.

In 1966, Dr. Posner established a solo optometric practice that later became the Larchmont-Mamaroneck Eye Care Group.

Dr. Posner was instrumental in establishing the SUNY State College of Optometry.

He was a Fellow of the American Academy of Optometry and was a president of the Westchester-Rockland Optometric Association in the 1970s.

Dr. Posner was an avid cyclist and longtime member of the Westchester Bike Club.

In his 70s, he became a certified spin instructor, teaching at a number of local fitness centers.

When not on a bike, Dr. Posner had a great interest in community theatre, performing in more than 20 productions.

Dr. Posner is survived by his wife Cathy, children Jackie (Evan) Glassman and Ted (Karen) Posner, and grandchildren Jacob, Abby, Justin, Erica, and Georges.

Memorial donations in Dr. Posner's name may be made to the Mastocytosis Society online at *www.tms-foracure.org/donate.php* or by mail at TMS Treasurer, The Mastocytosis Society, P.O. Box 129 Hastings, NE 68902-0129.

Woo to assume position as new dean of SCCO in July

Woo is an active AOA volunteer and past president of the Texas Optometric Association

The Southern California College of Optometry (SCCO) appointed AOA volunteer and Texas Optometric Association (TOA) past president Stan Woo, O.D., as dean.

Dr. Woo served as chief of the Vision Rehabilitation Service, was founding director of the University Eye Institute's Center for Sight Enhancement and director of the Residency in Low Vision Rehabilitation at the University of Houston College of Optometry (UHCO).

He will begin his new duties at SCCO in July 2013.

"We are pleased to welcome Dr. Woo to the SCCO Community," said SCCO President Kevin L. Alexander, O.D., Ph.D. "He brings a wealth of diverse expertise to the position encompassing academic, clinical and organizational aspects of optometry and health care."

From left, newly named SCCO Dean Stan Woo, O.D., and SCCO President Kevin Alexander, O.D., Ph.D.

Dr. Woo received his Doctor of Optometry degree from the University of California at Berkeley and a Master of Vision Science from UHCO.

He also completed a residency in Low Vision Rehabilitation at UHCO.

Dr. Woo is a Diplomate in Low Vision, American Academy of Optometry, and a Diplomate in Optometry, American Board of Optometry.

He will complete an executive Master of Business Administration degree with a concentration in medical and health care management from Rice University in May.

In addition to volunteering for the AOA and TOA, Dr. Woo has served many professional organizations including the National Board of Examiners in Optometry, Department of Veterans Administration, and American Academy of Optometry.

He has lectured nationally and internationally on many topics including vision rehabilitation, retinal disease and pharmacology.

Dr. Woo is married to Lisa Woo, O.D., and they have three children, ages 8, 5 and 4.

CLCS announces student/resident photo contest

The AOA Contact Lens and Cornea Section (CLCS) announced its 2013 CLCS Student/Resident Photo Contest. The CLCS is inviting students and residents to submit an outstanding digital image paired with a brief case report that involves contact lenses and anterior segment topics.

The overall winner will receive a $1,500 travel grant to attend Optometry's Meeting®, a trophy with the student's name engraved and an AOA Gallery Print (20" X 24") canvas of the winning image.

Runners-up will each receive a $1,000 travel grant to attend Optometry's Meeting® and an AOA Gallery Print (20" X 24") canvas of their image.

The digital image submissions may be clinical, abstract, or action, and the case report supporting the photo needs to contain 500 to 1,000 words. Photo release forms are required with submitted entries.

Photo topics may include:

- Care and Compliance in Contact Lens Success
- Contemporary Management of Ocular Surface Disease
- Contemporary Management of Astigmatism
- Contact Lens Problem-Solving Beyond Oxygen
- Most Challenging Contact Lens Case

Criteria and rules are as follows:

1. Must be a CLCS member.
2. Meet submission deadline of April 5, 2013, electronically to *CLCS@aoa.org*.
3. All must be original and in digital format (TIFF or JPEG)
4. Photos must complement the case report description of 500 to 1,000 words and reference peer-reviewed literature
5. Include submitter's name on digital image file.
6. Include full name, address, phone number, e-mail address, and school on cover page of case report.
7. Submissions must include a patient release form for permission to use photos.
8. Winners must attend Optometry's Meeting® CLCS function to receive travel grant (CLCS function will be determined in May).
9. Winners must provide W-9 (or W-8 international) to receive travel grant.

Submitted photos become the property of the AOA CLCS. Students and residents may submit more than one entry. Submissions may be sent to *CLCS@aoa.org*.

For more information, contact Capucine Chatman-Williams at *CCWilliams@aoa.org* or 800-365-2219, ext. 4161 or visit *www.aoa.org/clcs.xml*.

'Ask the Codeheads'

Confessions of medical records 'experts'

Edited by Chuck Brownlow, O.D., Medical Records consultant, AOAExcel™

There seems to be an abundance of people around health care calling themselves "experts" or who are referred to by others as "experts."

As consultants, we think it's time we "come clean" and provide our impression of what an "expert" really is.

First, since our area of interest includes issues related to medical record-keeping and coding, let's investigate what an "expert" in this area has that others may be lacking.

1. Interest—In order to learn anything, one must first be interested. With respect to medical record-keeping it seems many health care professionals believe they can provide care and keep records without knowing or complying with the rules related to medical records. A consultant or expert in this area, whether she or he really wanted to be or not, first had to develop an interest in learning more.

2. Resources—Medical record-keeping has national standards that make it pretty straightforward to develop an understanding of what constitutes good medical records and what is required to choose procedure, office visit, and diagnosis codes accurately. All of the necessary resources and references are readily available and actually quite inexpensive, especially when compared to the fines and repayments that can result from not being familiar with the rules related to medical records.

The three key resources are:

- Current Procedural Terminology* (CPT © American Medical Association),
- International Classification of Diseases, 9th Revision, and
- The Documentation Guidelines for the Evaluation and Management Services, 1997, (rules for choosing 99000 office visit codes).

Fortunately for AOA members, these references are available as a two-volume set through the AOA Marketplace, as AOA Codes for Optometry ($145), *www.aoa.org/onlinestore*. AOA members and their staff may also access *www.aoacodingtoday.com* for information related to Current Procedural Terminology (CPT) and International Classification of Diseases (ICD) codes, and find many resources available at *www.excelod.com/coding*.

*The American Medical Association (AMA) CPT is the only official CPT. There are "substitutes," but you must have the AMA CPT, as its definitions are the only ones nationally recognized and required by Health Insurance Portability and Accountability Act (HIPAA) for use by health care providers and insurers.

There…that's it. If you have the interest and you have the resources and references, you are well on your way to being an "expert" in the area of medical record-keeping and accurate procedure, office visit, and diagnosis coding.

Wait. There is one more important necessary element to becoming familiar with the rules for medical records and coding…

3. Motivation—It's clear that doctors and staff must be motivated in order to develop the interest and to seek out and use the resources. Sadly, the third element, motivation, may finally arise in health care practices because of the looming threat of audits of medical records and claims by Medicare contractors and by other insurers.

All provider agreements include a stipulation permitting the insurer to audit doctors' records related to claims for payment.

These audits are all based on the resources listed above, so keeping records based on those resources prepares physicians for doing well in audits.

There is no alternative now. Every physician and all staff involved in medical records, coding, and preparation and submission of claims must be accurately applying the rules for medical records and coding. They must be "experts" for their own practices.

As consultants in these important areas, often accused of pretending to be "experts," we "Codeheads" urge optometrists and key staff to develop the **Interest**, to purchase and utilize the **Resources**, and to respond positively to the **Motivation** to become "experts" yourselves…You will be glad you did!

Every physician and all staff involved in medical records, coding, and preparation and submission of claims must be accurately applying the rules for medical records and coding.

AOAExcel™ Medical Records & Coding Resources

The following resources are available to AOA members through AOAExcel™. Visit *www.ExcelOD.com/Coding*.

- "Frequently Asked Questions" for members-only, provides detailed answers to medical records and coding questions.
- AskTheCodingExperts@ExcelOD.com offers AOA members-only the opportunity to email their coding questions and have them answered by a topical expert in medical records and coding.
- Medical Records and Coding Webinars are provided as a no-cost AOA member-only benefit to educate doctors and staff on medical record-keeping and coding.
- The AOAConnect social networking site features a Coding & Billing Group where AOA members, students, volunteers and staff can share information that specifically relates to coding and billing (*connect.aoa.org*).
- AOACodingToday.com is an AOA member-only benefit available to all AOA members at no cost (previously $349). AOACodingToday.com is a Web-based resource for information related to procedure and diagnosis codes, national and local coverage rules, and Medicare relative value information.
- AOA.ReimbursementPlus.com Suite, a customized version of the industry-leading Current Procedural Terminology (CPT) data and information service, ReimbursementPlus® is the leading cloud-based service for any information related to procedure and diagnosis codes, fee analysis, Centers for Medicare & Medicaid Services (CMS) reimbursements, national and located coverage rules, Correct Coding Initiative (CCI) edits and any other CPT information desired, all specific to the practitioner's ZIP code. *AOA.ReimbursementPlus.com* provides critical real-time information that will greatly benefit AOA members in medical coding and compliance within their eye care practices.
- Codes for Optometry is available from the AOA Marketplace for $140. It is a two-volume set including Current Procedural Terminology© American Medical Associaiton codes and a separate volume of diagnosis codes used in eye care, Medicare's Correct Coding Initiative, the Healthcare Common Procedure Coding System (HCPCS) codes for reporting materials in Medicare, and the Documentation Guidelines for the Evaluation and Management Services. Codes for Optometry is available on a CD in a searchable format.

AOAExcel™ is devoted to assisting members in dealing with the challenges of everyday practice life, including those related to insurance programs.

The AOA is excited to bring this expertise directly to members' offices as a value-added member beneift. Many of these benefits are provided at no cost or at greatly reduced cost to AOA members.

AOAExcel™ offers Business & Career Resources

The following resources are available to AOA members through AOAExcel™. Visit *www.ExcelOD.com*.

❖ Optometry's Career Center® provides a national, online database and career matching service that helps you find jobs, partners or candidates in the optometric field across all 50 states and the District of Columbia. Visit *www.Optometrys Career Center.com*.

❖ **'Frequently Asked Questions'** for members only, provides detailed answers to business and career questions.

❖ **BusinessAndCareerOD@ExcelOD.com** offers AOA members the opportunity to email their practice management questions and have them answered by a topical expert in buying/selling agreements, bringing in associates, staff management, and other practice management topics.

❖ **Business and Career Webinars** are no-cost AOA member-only benefits to educate doctors on how to navigate their career paths, from practice entry, to management, growth, and succession planning.

❖ **AOAConnect** is a members-only social networking site with a Practice Pathways Group where AOA members, students, volunteers and staff can share information on how to successfully transition into or out of a practice. This includes, but is not limited to, the buying or selling of an optometric practice.

❖ **OptometryCEO.com** provides relevant, non-industry supported insight into daily practice management successes and unforeseen mistakes of a private-practice optometrist.

❖ **Wells Fargo Practice Finance** is the source for acquisition and expansion financing. Market data reports provide indispensable geographic and demographic data. The program includes customized financing, business planning tools and a network of resources.

❖ Practice Pathways at Optometry's Meeting® gives both buyers and sellers the facts they need to successfully transition a practice. You'll learn the process of transferring practice ownership from doctors who have been there, principles of winning relationships and leadership, the importance of communication, and hands-on tools to retain patients. The series will cover practical knowledge, and the legal, financial, and tax aspects. For more information, email *AOAExcel@ExcelOD.com*.

The AOA is excited to share all these resources with members, bringing much expertise right into offices as value-added member benefits. Even better, much of this is provided at no cost or at greatly reduced cost to AOA members. Visit *www.ExcelOD.com*.

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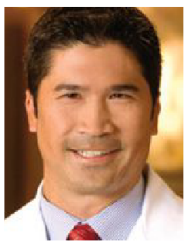

Coding for Cataract Co-Management

Join Dr. Whitley as he reviews proper billing and coding pearls for cataract co-management.

Tuesday, Mar. 12, 11 a.m. CST
Tuesday, Mar. 26, 11 a.m. CST

Speaker: Walt Whitley, O.D., MBA
AOAExcel™ Medical Records Consultant

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Medical Model Branding

Join Dr. Fleming as he explains the steps to becoming a well-branded medical optometry practice.

Wednesday, Mar. 13, 9 a.m. CST

Medical Model Dispensing

In the medical model of practicing optometry, the art of refraction and dispensing of glasses is not lost, but in reality, enhanced. Dr. Fleming will share the message that is delivered to patients to enhance their medical experience while reinforcing the method of delivering treatment.

Wednesday, Apr. 3, 4 p.m. CST

Speaker: Chad Fleming, O.D.
AOAExcel™ Business & Career Coach

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Optical to medical: The great evolution of practice

By Chad Fleming, O.D., AOAExcel™ Business and Career coach

Breaking up is hard to do. Whether you are ending a relationship or firing an employee, the breakup is always very difficult.

You are faced with having to tell someone they are not a good fit for you. You have postponed the ending as long as you possibly can. Let's face it—you are avoiding the situation altogether. Unfortunately, you may be causing yourself more pain in the long run by not ending your current situation.

As optometrists we are faced with many endings and new beginnings. We see new patients every week while watching previous patients move away. We watch products in the dispensary be replaced with newer, better performing products. And we watch our way of practice evolve over time. There is a season for all things in optometry and in life. Like the states of the north experiencing winter before the southern states, so are many optometry practices experiencing the necessity to offer patients medical eye care.

Medical eye care does not come at the cost of abandoning optics and dispensing. Medical eye care reinforces the need for all patients to view optometrists as the primary eye care providers. Successful practices are doing exactly this. They incorporate medical eye care without losing the benefits of an optical dispensary.

Here are a couple of steps to help identify you and your practice as primary eye care providers.

❖ **Prescribe Frames/ Lenses for Medical Reasons:** When was the last time you prescribed sunglasses for dry eye? All communities have patients with dry eye; however, Wichita, where I practice, is one of the worst cities to live in for dry eye and allergies. For me, prescribing sunglasses for dry eyes results in referrals from enthusiastic patients who tell their friends all about it.

❖ **Staff Education Focus on Primary Eye Care:** The phrase "culture is caught, not taught" is so true with leading your staff. They are replicas of the leader, you, and they will emphasize and deemphasize exactly what you do. When they see you referring dry eye patients or all diabetic patients to another doctor, they will immediately assume optometrists do not treat these patient types. Then when they are conversing with friends and family, they will express the same message. You will find that when you start educating staff about what you do in the exam room, they will begin encouraging patients who have eye problems to schedule an appointment with you. This of course requires you to treat and manage medical eye problems. (More information and ideas can be found at *http://bit.ly/UFeSEP*.) The AOA's Paraoptometric Section (*www.aoa.org/x4940.xml*) and AOAExcel™ (*www.excelod.com*) are good resources to educate your staff on medical eye care and billing and coding. Sales representatives may also educate them on a particular product or instrument.

Medical eye care reinforces the need for all patients to view optometrists as the primary eye care providers.

Do you prescribe sunglasses to all your cataract patients? How about prescribing sunglasses to younger individuals to protect their eyes from the long-term effects of ultraviolet (UV) damage? Do you regularly prescribe wrap sunglasses with foam or silicone inserts for your dry eye patients? These are only a couple of examples pertaining to prescribing optical solutions for your medical eye care patients. The AOA offers resources and education through its SUN Initiative. And like all AOA EyeLearn™ courses, is available free of charge to AOA members (*www.aoa.org/eyelearn*). When patients view you as their primary eye care provider, they will turn to you no matter what type of eye problem they have.

❖ **Hire a New OD:** There are many optometrists who want the benefits of a new associate but do not want to pay the price. However, all good things come at a price.

Remember how you felt about the purchase price of optical coherence tomography (OCT)? You agonized over the cost of an OCT until you had one in your office and you realized the benefits of such an instrument. An associate, if given a clear job description and fair compensation, may be exactly what you need to bring your practice to the 21st century.

The new associate should add value to the practice in many ways. One of those is the depth of knowledge they have with medical eye care. Students today are being trained medically to work hand in hand with fellow physicians and others in the medical community. If you refer more primary care then you treat, if you are billing 92014 98 percent of the time, or if you are just uncomfortable treating medical eye problems, then it is time for you to hire a new OD.

Our profession has evolved over many years to become the primary eye care provider for our communities. Choosing to embrace the times can be very frightening, but also very rewarding.

If you are planning on selling your practice for the highest dollar amount, you will want to ensure the medical model is the perception your patients have about the practice. This perception will continue to bring growth and prosperity to a profession that continues to face the ever-increasing pressures of lower reimbursements and greater competition.

Countdown of the Top 10 *AOA News* stories

No. 7: AOA became an agency member of the APHA in 1963, later forming the Vision Care Section

*Editor's Note: To commemorate 50 years of groundbreaking news in optometry, we are publishing the Top 10 AOA News stories as selected by our readers from all five decades. Please share your commentary and personal stories on the site as well (*http://connect.aoa.org*). The AOA News ran the following article in January 1963, the same year the AOA become an agency member of the American Public Health Association. This opened the door for the later formation of the Vision Care Section in 1979. Mel Shipp, O.D., Dr.PH, MPH, was elected APHA president in 2011.*

The American Public Health Association's 90th annual meeting in Miami Beach was attended by 6,000 registrants including a delegation of 21 representing AOA.

As in the several previous meetings, the AOA presented an exhibit in the Scientific Section. The theme dwelt upon modern tests for pre-school and early-school children, and emphasized the 10 points essential to educational achievement. Educational literature was distributed.

Doctors Richard L. Haney and Felix A. Koetting officially headed the exhibit section, with Dr. Ben Rosenkranz and 14 Dade County Society optometrists manning the booth.

Optometric leaders attending the sessions included AOA President-Elect W. Judd Chapman, O.D.; William Greenspon, O.D., director of the Department of National Affairs; Paul Lewis, O.D., of the Committee on Visual Problems of Children and Youth; and Mr. David Sharman, manager of the AOA Washington office.

Optometry's interest in the meeting was provoked by sparkling educational sessions, the importance of projected resolutions and an opportunity to meet representatives of the diversified disciplines composing the APHA.

Of particular interest to Optometry was a resolution involving the upgrading of non-medical personnel. The resolution, which included "refractionists" in the category, was finally defeated.

An AOA hospitality room was offered to provide a central meeting place for visitors and guests. Miss Helen Gillespie, executive secretary of the Florida Optometric Association, was hostess.

Optometrists are expressing an increased interest in public health activities, AOA officials noted. Optometric memberships in the APHA have doubled in the past few months.

An APHA spokesman also remarked on the surge of memberships, commenting he felt optometrists can contribute much to the organization and that optometry can benefit from contact with the other professions in APHA.

The 6,000 attendants at the annual APHA conference came from every state and a number of foreign countries.

A total of 400 speakers and several hundred scientific and technical exhibits were offered.

The 1963 meeting will be in Kansas City.

An APHA spokesman remarked on the surge of memberships, commenting he felt optometrists can contribute much to the organization and that optometry can benefit from contact with the other professions in APHA.

Editor's Note: The following ran on the front page of the December 1979 AOA News.

News Focus

The American Public Health Association (APHA) has voted to establish a vision care section. A substitute for the AOA's original recommendation to create an optometry section, the APHA action means the Medical Care Section's Vision Care Committee, which represents 20 percent of the section's enrollment, now has achieved its own sectional status within 2 years after being established.

More than 600 doctors of optometry currently are APHA members, and these ODs, as well as others interested in vision care, will be invited to transfer to the new section.

Burton H. Skuza, O.D., of Minneapolis, a past president of the Minnesota Optometric Association, is the current chairman of the APHA Vision Care Committee.

Send letters to:
Editor, AOA News
243 N. Lindbergh Blvd.,
St. Louis MO 63141
TLTabb@aoa.org

The AOA News reserves the right to edit letters submitted for publication.

Votes for the top story of the past 50 years

In reflecting upon the gains of the past, many members logged on to AOAConnect and voted for the top story of the past 50 years. Here are some of the choices:

1963—AOA became an agency member of the American Public Health Association.
1964—AOA files complaint with U.S. Dept. of Justice alleging restraint of trade and conspiracy on the part of the American Medical Association
1967—Council on Clinical Optometric Care is formed
1968—American Optometric Student Association (AOSA) formed
1970—Alabama legislature authorizes the establishment of a school of optometry, the first to be an integral part of a medical center (UAB)
1971—First DPA Law passed - Rhode Island
1976—First TPA Law passed— West Virginia
1977—U.S. Supreme Court reverses four decades of precedent and holds that professionals may utilize truthful advertising (Bates v. Arizona State)
1986—Medicare parity legislation allows reimbursement for optometrists for health-related services performed on nonaphakic patients.
1988—Federal Trade Commission approves trade regulation (Eyeglasses II)
1994—Publication of first AOA Optometric Clinical Practice Guidelines, providing ODs evidence-based recommendations for patient care
1998—First state law specifically authorizing the use of lasers by optometrists for certain treatment purposes enacted in Oklahoma
2000—Kentucky became the first state to require children to have a vision examination before entering the public school system
2002—AOA launches the Healthy Eyes, Healthy People® program
2005—InfantSEE® program established
2008—AOA establishes the National Commission on Vision and Health (NCVH)
2009—AOA House of Delegates votes in favor of establishing the American Board of Optometry (ABO) to develop and implement the framework for optometric board certification

NEI resources can help ODs educate growing number of Americans with vision loss

Optometrists can educate patients with the National Eye Institute's (NEI) newly introduced 20-page large-print booklet and series of videos to help people adapt to life with low vision. The materials were released during Low Vision Awareness Month, February 2013.

The booklet, "Living with Low Vision: What you should know," urges people with low vision to seek help from a low vision specialist and provides tips to maximize remaining eyesight, enabling them to safely enjoy a productive and rewarding life.

The videos feature patient stories about living with low vision. Another video, targeted to health care professionals, emphasizes the importance of informing patients with vision loss about vision rehabilitation services.

The booklet and the videos were developed by the NEI National Eye Health Education Program (NEHEP).

A 2012 report cosponsored by the National Institutes of Health estimates that 2.9 million Americans are living with low vision. The number is projected to increase 72 percent by 2030 when the last of the baby boomers turn 65. Most people with low vision are 65 years old or older.

"I encourage anyone with low vision to seek guidance about vision rehabilitation from a low vision specialist," said NEI Director Paul A. Sieving, M.D., Ph.D. "For many people, vision rehabilitation can improve daily living and overall quality of life."

As described in the booklet and videos, vision rehabilitation services include:

- training to use magnifying and adaptive devices
- learning new daily living skills to remain safe and live independently
- developing strategies to navigate inside and outside the home
- providing resources and support to help patients with vision loss

"A vision rehabilitation plan helps people reach their true visual potential when nothing more can be done from a medical or surgical standpoint," said Mark Wilkinson, O.D., a low vision specialist at the University of Iowa Hospitals and Clinics and a NEHEP planning committee member. "Vision rehabilitation can make a world of difference to a person adjusting to vision loss and should be considered part of the continuum of care. I urge health professionals to help their patients with low vision seek vision rehabilitation services."

The new NEI booklet and videos along with other resources for people with low vision can be viewed and downloaded at *www.nei.nih.gov/lowvision*.

SYVM,

from page 3

nutrients, such as lutein and zeaxanthin, for maintaining and improving eye health.

The AOA's American Eye-Q® survey showed that nearly half of all Americans (49 percent) still believe carrots are the best food for eye health. While carrots do contain nutritional value by supplying beta-carotene, which is essential for night vision, spinach and other dark, leafy greens are the healthiest foods for eyes because they naturally contain large amounts of lutein and zeaxanthin.

The AOA recommends the following foods that contain key nutrients for eye health:

- Lutein and zeaxanthin: To help reduce the risk of developing age-related macular degeneration (AMD), eat one cup of colorful fruits and vegetables such as broccoli, spinach, kale, corn, green beans, peas, oranges and tangerines four times a week.
- Essential fatty acids: Studies suggest omega-3 fatty acids such as flax or fleshy fish such as tuna, salmon, or herring, whole grain foods, lean meats and eggs may help protect against AMD and dry eye.
- Vitamin C: Fruits and vegetables, including oranges, grapefruit, strawberries, papaya, green peppers and tomatoes, can help minimize the risk of cataracts and AMD.
- Vitamin E: Vegetable oils, such as safflower or corn oil, almonds, pecans, sweet potatoes, and sunflower seeds are powerful antioxidants that can slow the progression of AMD and cataract formation.
- Zinc: A deficiency of zinc can result in poor night vision and lead to cataracts; therefore, consuming red meat, poultry, liver, shellfish, milk, baked beans, and whole grains on a daily basis is important.

For a list of quick and simple recipes that promote healthy eye sight and vision, visit *www.aoa.org/x11857.xml*.

ARBO releases new OE Tracker mobile app for smartphones

The Association of Regulatory Boards of Optometry (ARBO) announced the development of a new Optometric Education (OE) Tracker mobile app, available for Android and iPhones. The app was created to assist COPE-approved administrators and optometrists in recording continuing education (CE) course attendance.

"OE Tracker has entered into the next phase of tracking attendance electronically with the new mobile app," said Richard Orgain, O.D., chair of the OE Tracker Committee. "Since we have introduced it, we've gotten great feedback on how quick and easy it is to use. Optometrists love the fact that they receive immediate confirmation of credit on their smartphone. We encourage all the optometrists and COPE administrators to try the new OE Tracker mobile app."

Attendance is easily recorded by scanning a course-specific QR code that submits the data directly into OE Tracker immediately after a course is completed.

OE Tracker is used by optometrists, continuing education providers and licensing boards to electronically track, report, and audit CE attendance.

The attendance information is usually supplied directly to ARBO by CE administrators and providers, but ODs can also fax their CE certificates to the ARBO office to have the hours entered into their OE Tracker account.

Not only is it easy to use, but the app is free to optometrists and COPE-approved administrators.

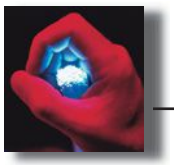
The addition of the OE Tracker mobile app now allows attendance from COPE courses to instantly be sent to OE Tracker by simply scanning a QR code.

Both CE attendees and COPE administrators can download the app to their iPhone or Android phone to record attendance.

Not only is it easy to use, but the app is free to optometrists and COPE-approved administrators.

"I'm very excited that the OE Tracker mobile app has made a positive change in the way that CE providers and optometrists record CE attendance. We're thrilled that ARBO is able to provide this new tool to the optometric community, and I want to thank the OE Tracker Committee for the time and effort it took to develop the app," said ARBO President Michael Ohlson, O.D.

For more information on the new OE Tracker mobile app and a complete list of directions for use, visit *https://www.arbo.org/smart_app.php* or contact Lisa Fennell, ARBO executive director, at 704-970-2710 or *lfennell@arbo.org*.



Spot on!

By Dominick M. Maino, O.D., and Geoffrey Goodfellow, O.D.

AOA members are constantly trying to use technology to serve their patients at the highest level and at the same time improve overall efficiency of their office procedures. The many tools used include those that assess ocular health and an electronic health record (EHR) system that not only meets the requirements of third-party payers and government regulations, but also improves office communication and efficiency.

Frequently, when it comes to refractive care, optometrists tend to rely more on retinoscopy and the standard "which is better, one or two?" subjective refraction and less upon technology. This may be changing in the near future as many new choices are becoming available in the area of auto-refraction.

Although auto-refraction technology has been around for decades, there did not appear to be any one device that could work with all populations typically evaluated by optometrists. Various auto-refractive instruments worked well with adults but not children, while others did not seem to work with those patients with special needs at all. Some early refractive error screening technology initially required one to send in pictures to be evaluated by an outside source before you could tell the individual what type of refractive error was present.

This is changing, and the change may lead to consequences yet not imagined (see *http://newsfromaoa.org/2012/09/13/diy-refractions-disruptive-innovation-that-affects-science-people-and-the-economy/*). There may be one fairly new device, however, that could change how we practice right now. This device is offered by PediaVision and is called the Spot.

The Spot is relatively small, lightweight (2.5 lbs.) and easily transportable (slightly bigger than one of those more expensive digital SLR cameras with a fairly large zoom lens attached). The testing sequence is straight forward. You turn it on, enter the appropriate data, reduce the room illumination, have the patient look at the camera (the patient fixates lights that can be associated with various sounds), and then within about a second or so, obtain the desired results.

The Spot is WiFi-enabled and has a battery life of about four hours. With it, you can measure a range of refractive errors from -7.50 to +7.50 and up to 3D of cylinder. The patient's pupil size can be as small as 4mm and as large as 9mm with a pupillary distance from 35-80mm. The device can be mounted on a tripod and also has a neck strap and safety wrist strap mounts.

Once the data is captured, the screen displays the patient's PD, pupil size, eye alignment, the refractive error spherical equivalent and the complete refractive error (sphere, cylinder, axis) in either "+" or "–" cylinder form. You can also print a hard copy of the findings that can be included in your patients' files or scanned as a PDF and attached to your EHR patient database. When used as a vision screening device, the printout also offers a severity index and call to action recommendation. Any finding printed in red suggests problem areas to be investigated, and at the top of the page (also printed in red) will be a call for action such as "Complete Eye Exam Recommended."

Firsthand experience

AOA certified paraoptometric Katherine Simpson of Lyons Family Eye Care in Chicago notes that the Spot "is an incredibly efficient way to screen children" and "it is much easier to obtain a reading on children because it doesn't scare them by forcing their head into an instrument."

Simpson also said it is an efficient way to assess refractive error and is often more accurate for children and patients with special needs than other auto-refractors available in the office. Even more telling is that she would suggest to her employer, Stephanie Lyons, O.D., that if she had to buy the Spot again, that the investment was well worth the cost.

Audrey Reed, director of National Programs, Essilor Foundation, has been using the Spot for some time as well. She and her volunteers conduct vision screenings that, when needed, lead to an immediate eye examination by an optometrist. She notes how easy it is to teach her volunteers to use the Spot.
Reed also said they used this auto-refractor with 200 children over a two-day period and only had four children with whom the screener did not appear to function well.

Both Simpson and Reed commented on how the need for a darkened room and fairly large pupils sometimes detracted from the Spot's usefulness, but its overall usability, ability to save data on a jump drive, and wireless connectivity far outweigh any limitations. Another possible limitation to the device noted by some is that using a finger to input data can be difficult, but that if you use the rubber end of a pencil data input becomes much easier and reliable.

After using the Spot in my (Dr. Maino's) private practice (Lyons Family Eye Care) for several months, I find it does what it is supposed to do pretty well. I also found it easy to use, and even the youngest child and more difficult patient with special needs will often respond in such a way that a reliable reading can be obtained. The Spot is a part of the pre-examination sequence that our AOA certified paraoptometrics routinely use prior to my conducting a comprehensive examination.

Rachel, an optometric technician/optician at Lyons Family Eye Care, conducts a pre-examination sequence using the Spot on smiling patient Carie Zaas, whie her mom, Alina, looks on.

As new advances are made in this area and the next-generation Spot appears on the horizon, our wish list includes an expanded range of refractive error determination (+/-7.50 is just not adequate when you work with special-needs patients), voice input of data, an even faster capture time, and the ability to work in a wide range of ambient light including normal room illumination.

Although Jeff Mortensen, vice president Business Development of PediaVision, couldn't comment on future incarnations of the Spot, he did say the SPOT does not replace the comprehensive eye examination and that it "is an appropriate tool for use as a part of the doctor's pre-examination sequence" and can be used to "build awareness of various vision issues including not only refractive error but also binocular vision dysfunction."

A few caveats and unintended consequences

It is our understanding that pediatricians and others may be using this and similar devices within their office visit sequence. This is not necessarily inappropriate unless the patient or parents of the patient interprets the findings in such a way that they believe a full, comprehensive eye examination was completed. This can often result in a false sense of security by the parents and devastating, unintended consequences for the patient if a serious eye disease, binocular vision dysfunction or refractive error is missed. We would also caution those conducting vision screenings that if the screening does not lead to better outcomes, a current review of the literature suggests a comprehensive eye and vision evaluation be conducted by a doctor of optometry as soon as possible.

More information about the Spot can be found at *www.spotvisionscreening.com*.

Dr. Maino is a professor at the Illinois College of Optometry (ICO) and a Distinguished Practitioner of the National Academies of Practice. He can be contacted at dmaino@ico.edu. *Dr. Goodfellow is an associate professor of optometry at ICO and the college's assistant dean for curriculum and assessment. He can be contacted at* ggoodfel@ ico.edu.

AOA Paraoptometric Section calls for council applications

Paraoptometric Council Chair Beverly Roberts, CPOT

The AOA is seeking new Paraoptometric Section Council members for 2013-2014. All applicants must submit their Intent to Run forms by April 30, 2013.

"We need the help of paraoptometrics with a personal goal to be part of the team and the vision of this organization," said Paraoptometric Council Chair Beverly Roberts, CPOT. "Remember that a winning team is made up of individuals all with the same goal and purpose in mind. We are the team that helps paraoptometrics make a positive difference in the lives of their patients. Now is the time for you to join the winning team."

Open Paraoptometric Section Council positions include chair-elect, vice chair, secretary, and trustee. These positions are one-year terms. The section's bylaws do not stipulate for which office a candidate may run.

For more information, contact the Paraoptometric Section at 800-365-2219, ext. 4108 or email *PS@aoa.org*.

Staff training key to progress

Many practitioners may question the return on investment on providing training and education to their staff. The AOA Paraoptometric Section offers optometrists other considerations when looking to improve their staff along with their practice.

"Recognition of paraoptometry as a professional career lies with today's paraoptometrics and the optometrists who support that segment of the profession," said Jill Luebbert, CPOT, a past section chair.

Refuting false assumptions

"If I pay for training my staff, they will leave for employment elsewhere, and I'm left empty-handed!"

Many practice owners may feel this way, but according to Donald Sanders, Ph.D., in his book "Retain or Retrain," "Between sixty and sixty-five percent of the people I interviewed said they left because of issues related to their direct supervisor, for example: not being listened to, not being challenged, no sense of personal development, supervisor style of "my way or the highway," lack of respect, obvious favoritism (particularly in terms of promotional opportunities), no teamwork, rules not applied equally to everyone, no encouragement/ praise/ recognition, a sense of being ignored or isolated and boring, repetitious work (knowing other types of work were available)."

"Recognition of paraoptometry as a professional career lies with today's paraoptometrics and the optometrists who support that segment of the profession."

Some of the main reasons cited in the book for leaving were due to management issues and lack of education opportunities. The practice could be more at risk for losing valuable employees if it does not provide education opportunities for its staff.

1. "Staff training is expensive!" The AOA Paraoptometric Section offers education opportunities as member benefits. The cost calculates to only pennies a day. The newest offerings include:

- Self-Study Course for Paraoptometric Assistants and Technicians
- Billing and Coding: Foundations for Beginners webinar series

Section continuing education courses, webinars, and articles are designed to be:

- Convenient—self-paced, accessible for any schedule, available 24/7, and do not require physical attendance at a conference or event.
- Self-directed— allows students to choose content appropriate for differing interests, needs, and skill levels.
- Cost-Effective— costs are frequently less than what is typically charged for registration fees, hotel accommodations, meals, time off from work and child care.

Many optometrists are unaware of the variety of training options provided by the AOA Paraoptometric Section.

Training programs and products are tailored to meet the optometric practice's specific needs.

To find out more about how continuing education allows paraoptometrics to stay current in the field of eye care and the importance of studying direct patient care and office competency, contact *PS@aoa.org*.

THE BOTTOM LINE

Tax law changes may be felt for many individual practitioners

By J.R. Armstrong, CPA, and Jodi Permenter, CPA

By passing the American Taxpayer Relief Act of 2012 (ATRA) in the early hours of Jan. 1, 2013, Congress managed to avoid, or at least postpone, the imminent and oft-discussed "fiscal cliff."

The act permanently codified many of the temporary provisions enacted under President George W. Bush. For the majority of Americans, the act has kept the status quo by avoiding automatic tax hikes to low and middle-class families that would have occurred had the temporary tax cuts been allowed to expire.

However, the ATRA constitutes the largest tax increase in almost two decades, and many high-income taxpayers will notice higher tax rates and fewer deductions as they file their 2013 tax returns.

Tax rates

The ATRA has not changed the lowest six income tax brackets for individuals, but has added a seventh tax bracket of 39.6 percent for married taxpayers earning in excess of $450,000 ($400,000 for single filers) beginning in 2013. The higher tax rate will be taken in addition to the 3.8 percent Medicare surtax imposed on the lesser of (1) net investment income or (2) income in excess of $250,000 ($200,000 for single filers) implemented by the Affordable Care Act.

The Maximum Capital Gains Tax rates and Qualified Dividend Tax rates will remain the same for taxpayers falling into one of the first six tax brackets. As in prior years, taxpayers in the 10 to 15 percent income tax brackets will have a 0 percent long-term capital gains rate, and taxpayers in the 25 to 35 percent brackets will pay a 15 percent long-term capital gains rate.

However, taxpayers falling into the new 39.6 percent tax bracket will see a rise in their capital gains rate. Capital gains for these high-income taxpayers will be increased to 20 percent beginning this year.

Alternative Minimum Tax

The Alternative Minimum Tax (AMT), instituted in 1969, targeted high-income taxpayers who were able to avoid paying taxes by taking advantage of tax deductions in the law. The act originally allowed a $45,000 AMT Exemption, which was high enough to avoid affecting the middle class. However, this exemption was not indexed for inflation and had to be changed by congressional action, by way of an AMT "patch." Because the latest congressional patch expired Dec. 31, 2011, experts believed an additional 24 million taxpayers would be subject to AMT in 2012 without further action. Thankfully, the ATRA created a permanent fix to AMT instead of just another temporary patch, and the AMT exemption will now be increased along with the rate of inflation.

Pease and PEP

Pease Limitations and Personal Exemption Phase-outs (PEPs) reduce the amount of itemized and personal deductions high-income taxpayers can claim on their tax returns. Both were temporarily repealed in 2010, but, without any action on these items by ATRA, are scheduled to make a comeback in 2013.

Pease Limitations reduce the allowed itemized deductions for wealthy taxpayers. In 2013, taxpayers with income in excess of $300,000 ($250,000 for single filers) could see as much as a 20 percent reduction in the deductible amount allowed.

Personal Exemption Phase-outs are meant to reduce the personal deductions allowed for high-income taxpayers. Under ATRA, these taxpayers will experience a 2 percent reduction in their personal exemptions for every $2,500 of income they have more than $300,000 ($250,000 for single filers).

Expiration of the Payroll Tax Holiday

Although the ATRA extended many tax cuts, the Payroll Tax Holiday was not extended for 2013.

Employees enjoyed a 2 percent payroll tax rate cut for the past two years, dropping their Social Security Tax rate from 6.2 percent to 4.2 percent. Beginning in 2013, the rate reverted to 6.2 percent. For taxpayers earning more than $113,700 in wages, the 2013 Social Security wage cap, the increase will reduce their take-home pay by $190 each month. Also, taxpayers with wages in excess of $250,000 ($200,000 for single filers) will also be assessed an additional .9 percent Medicare surtax as a result of the Affordable Care Act.

Deductions

The deduction for student loan interest has been permanently extended, while deductions for mortgage insurance premiums, tuition and fees, and classroom expenses have been extended for two years. Also, the state sales tax deduction, which may be taken in lieu of the state income tax deduction, has been extended for two years.

Section 179 Depreciation Deduction limits were enhanced for 2012 and 2013. Section 179 depreciation allows businesses to deduct 100 percent of the purchase price of new assets up to the lesser of (1) $500,000 or (2) taxable income. Section 179 is reduced for businesses that had more than $2 million in capital acquisitions during the year.

Bonus depreciation was temporarily extended for another year, so businesses will continue to enjoy 50 percent bonus depreciation through Dec. 31, 2013. This bonus depreciation may be taken over and above the Section 179 limit.

Credits

The Child Tax Credit has been permanently extended, allowing a $1,000 partially refundable credit to parents with a child under age 17. The Child and Dependent Care Credit, a non-refundable credit of up to $6,000, was permanently extended for parents who pay for a nanny, day care, pre-school, or day camp for their child so that they can work or look for work. The Adoption Credit and Earned Income Tax Credit were also permanently extended without any changes. The American Opportunity Tax Credit, a dollar-for-dollar $2,500 credit available to full-time college students or their parents, was temporarily extended and will expire on Dec. 31, 2017, without further congressional action.

Filing deadlines

Although the ATRA has not changed the filing deadline for returns, the eleventh-hour legislation has left the IRS scrambling to comply with the changes. As a result, the IRS delayed the start of tax season. Most individuals with simple returns were able to file by Jan. 30, 2013.

However, individuals and businesses with more complicated returns, including those claiming education credits, residential energy credits, general business credits, or depreciation, are unable to file their return until late February or March.

How much will my taxes increase?

Although the ATRA avoided the catastrophic tax increases that would have occurred without congressional action, it is still the largest tax hike since 1994. This increased tax burden falls almost exclusively on America's upper class. Taxpayers with less than $300,000 in Adjusted Gross Income (AGI) will notice only a modest increase in their total income tax liability, if they notice an increase at all. Taxpayers with AGI between $300,000 and $450,000 will certainly feel the ATRA's effects and can estimate paying an additional $4,000 to $5,000 in 2013. Taxpayers with an AGI around $550,000 will owe approximately $10,000 to $12,000 in additional tax liability. It is important to consult with a tax adviser and adjust your estimated tax payments accordingly in order to avoid costly late-payment penalties and interest.

Looking forward

Despite the accomplishments of the American Taxpayer Relief Act of 2012, many other significant issues were not addressed. Congress failed to implement the $110 billion in spending cuts, often called sequestration, required by the Budget Control Act, opting instead to postpone the cuts until March in hopes that they will be able to pass a long-term deficit reduction package to replace the heavy-handed cuts. Additionally, Congress postponed raising the debt ceiling until May, and with politicians on both sides of party lines stating that they are not open to compromise, we can expect a long and heated debate before Congress reaches an agreement. It is clear additional changes are imminent as Congress addresses these issues.

Armstrong is a partner in the firm of May & Company, LLP. Permenter is a member of the professional staff of May & Company, LLP. The firm consults with optometrists in 30 states, assisting with their tax planning and preparation, QuickBooks support, and business planning. May & Company was established in 1922 and has offices in Louisiana, Mississippi, and Alabama. He can be reached at 601-636-4762 or by email at jarmstrong@maycpa.com.

Abbott Medical Optics

Alcon

Allergan

Bausch + Lomb

CooperVision

Essilor of America

HOYA Vision Care

Kemin Health

Luxottica Group

Optos

Shamir

TLC Vision Corporation

Transitions Optical

VisionWeb

Vistakon®, Johnson & Johnson Vision Care, Inc.

Bausch + Lomb recalls 27-gauge sterile cannula packed in Amvisc and Amvisc Plus OVDs

Bausch + Lomb is notifying heath care professionals of a Class I recall of certain Bausch + Lomb 27-gauge sterile cannula packed in the company's Amvisc 1.2 percent Sodium Hyaluronate (models 59051, 59081, 59051L, 59081L) and Amvisc Plus 1.6 percent Sodium Hyaluronate (models 60081, 60051, 60051L, 60081L) ophthalmic viscosurgical devices (OVDs).

The cannulas may leak viscoelastic material or detach from the syringe during injection. In rare incidences, detachment has resulted in serious patient injury.

Amvisc and Amvisc Plus are indicated for use as surgical aids in ophthalmic anterior and posterior segment surgery including cataract extraction, intraocular lens (IOL) implantation—for smooth in-the-bag placement of IOLs, corneal transplantation and glaucoma filtering surgery, and surgical procedures to reattach the retina.

Due to its lubricating and viscoelastic properties, transparency and ability to protect corneal endothelial cells, Amvisc and Amvisc Plus help maintain anterior chamber depth and visibility, minimize interaction between tissues, and act as tamponade and vitreous substitutes during retina reattachment surgery.

If operative injuries are observed post-operatively or reported by the patient, optometrists should be sure the injury was reported to the FDA.

The 27-gauge disposable cannula is only used during surgery.

Optometrists, who often provide first-day post-operative care, should be aware of this potential for injury or complication during a surgical procedure, according to the AOA Advocacy Group.

If operative injuries are observed post-operatively or reported by the patient, optometrists should be sure the injury was reported to the FDA as outlined in the information below.

The recall was announced Jan. 23, 2013.

The FDA MedWatch safety alert, including a link to the Recall Notice (with a list of affected lot numbers), can be accessed at *www.fda.gov/Safety/MedWatch/SafetyInformation/SafetyAlertsforHumanMedicalProducts/ucm336466.htm*.

Health care professionals and patients are encouraged to report adverse events or side effects related to the use of any health care products to the U.S. Food and Drug Administration's MedWatch Safety Information and Adverse Event Reporting Program:

- Complete and submit the report online: *www.fda.gov/MedWatch/report.htm*
- Download form (*www.fda.gov/Safety/MedWatch/HowToReport/DownloadForms/default.htm?source=govdelivery*) or call 800-332-1088 to request a reporting form, then complete and return to the address on the pre-addressed form, or submit by fax to 800-FDA-0178.

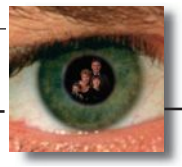
Brevium, First Insight announce certified integration for MaximEyes users

Brevium, Inc. a leader in Patient Reactivation Software, and First Insight Corporation, developer of MaximEyes Practice Management and certified electronic health record (EHR) software for optometrists, announced a certified integration that allows users of MaximEyes 11.0 practice management software to integrate with Brevium software.

"We are excited to announce that Brevium's Patient Reactivation Software is now available for MaximEyes customers," said Brett Gerlach, president of Brevium. "Like MaximEyes, Brevium has long served practices in the eye care community, so this partnership is a great strategic fit. The developers at MaximEyes have worked closely with us to ensure that this integration is of highest quality. They have a great team, and we look forward to continuing to work with them in the years ahead."

"Our partnership with Brevium paves the way for future integrations," said Nitin Rai, president of First Insight. "This new integration automatically searches every patient's history nightly to identify lost patients. Then it analyzes recalls to find patients who missed or never scheduled an appointment after receiving a reminder. Finally, it reviews claims data to identify patients with diseases such as glaucoma, diabetes, macular degeneration or cataracts who are overdue for a visit, even if no recall was ever entered. The contact list is always complete and current."

To learn more about the companies, visit *www.first-insight.com* or *www.brevium.com*.



Vistakon creates new group for professional development

Vistakon® Division of Johnson & Johnson Vision Care, Inc., today, announced the creation of a new Professional Development group, which combines its Professional Affairs, ODLean™ Consulting Program, and optometry school educational efforts into one department.

Past AOA president Dick Wallingford, O.D., has been named senior director, Professional Affairs. In this expanded role, Dr. Wallingford will continue to lead the company's professional affairs activities with associations and eye care practitioners, as well as oversee management of its optometry school programs.

W. Lee Ball, O.D., will continue to work with Dr. Wallingford to support these efforts.

Damian May, Pharm.D., has been appointed senior director, Strategy & Professional Development, responsible for working with the new organization to set the vision, strategy and roadmap for the group to meet the changing demands of the optometric marketplace.

"Vistakon® has a long-standing commitment to optometry and to the thousands of optometrists who prescribe our products," said Dave Brown, president, Vistakon®. "Under Damian and Dick's proven leadership, we believe we are well poised to help current and future optometrists prepare for and readily adapt to a complex and fast-changing healthcare environment."

Dr. May has been with Johnson & Johnson for seven years with experience in both the pharmaceutical and medical device and diagnostics sectors. Since 2008, he has been responsible for market access and strategy for Vistakon®, where his responsibilities included designing and implementing commercial, governmental and corporate strategies to address environmental changes and marketplace variables impacting product access and value delivery in the vision care marketplace.

Prior to joining Johnson & Johnson, he held positions focusing on health economics, clinical consulting, third-party reimbursement (commercial and governmental), outcomes research and market access within Pfizer Pharmaceuticals, Prudential Healthcare, Alcon Laboratories, and VHA, Inc. Dr. May maintains his status as a registered pharmacist in the state of Texas.

Dr. Wallingford joined Vistakon® in 2008. He was president of the AOA in 2005-2006. He is also the past president of the Maine Optometric Association and past president of the Maine Board of Optometry, serving 11 years by the governor's appointment. Dr. Wallingford served on an AOA committee or board continuously for over 28 years.

Dr. Wallingford is a graduate of the New England College of Optometry and has served on their Board of Trustees for over 8 years. He is a member of the Governing Board and the Treasurer of the World Council of Optometry, and the World Foundation for Optometry. He is also the past president of the Partnership Foundation for Optometric Education. Dr. Wallingford has been in private practice, a partnership specializing in contact lenses, and a large OD/MD practice with two surgical suites and a Lasik center.

Super Systems announces FastCoat system

Super Systems announces a new solution designed for independent practices called FastCoat, an affordable in-office lens hard coating system designed and engineered by Super Systems. It is priced with the small- to medium-size independent practice in mind.

FastCoat, combined with FastGrind, will open up practices to a brand new customer base to help grow their business. FastCoat expands the traditional range of FastGrind by allowing eye care professionals to offer polycarbonate lenses. The addition of polycarbonate to their FastGrind capacity will add a new profit center to their business.

Before this system, practices were limited to paying for hard coaters that were bulky and expensive or giving the order to a lab hence losing most of the profit. Now with FastCoat both of those problems are solved.

FastCoat is low cost and fits on a countertop measuring only 27" x 24" x 27". FastCoat makes utilizing FastGrind more appealing than ever before by offering a wider variety of quality products.

The easy to use system is manually operated with minimal training required. In fact, after watching a short video tutorial anyone is able to operate FastCoat, just like its counterpart FastGrind. The growth potential for optical dispensaries that implement the combination of both FastGrind and FastCoat is huge when compared with any equipment they are likely to purchase in 2013.

For more information, visit *www.superoptical.com*.

FoxFire announces EHR system Web-based compliance program

With an eye on the future, FoxFire Practice Management system was created using practical feedback from hundreds of offices across the country that expressed the need for a better, more efficient practice management system. FoxFire's certified electronic health record (EHR) powered by MedFlow offers an online compliance connection that eliminates staff error.

Other convenient features such as the Single Screen Exam and ePrescribing make patient visits a snap, allowing clients to see more patients and optimize their practice efficiency. FoxFire EHR's Image Management and Advanced Drawing Capabilities allow doctors to accurately and precisely diagram patient conditions, facilitating a higher standard of care.

New innovations are taking FoxFire EHR by MedFlow to a new level.

Corcoran Compliance Connection

Imagine an office where your EHR automatically queries an online expert system so you don't need to worry or spend time on coding. With the Corcoran Compliance Connection, an office such as this is a reality. The Corcoran Compliance Connection is a Web-based compliance and coding program for EHR that eliminates human errorand offers clients an easy and effective way to be billing compliant.

In fact, the Corcoran Compliance Connection captures thousands of dollars due to undercoding and reduces the likelihood of fines or penalties during post-payment review. It's a sure-fire way to ensure that your practice has compliant charting and coding while optimizing revenue
per patient.

The Corcoran Compliance Connection offers:

- Accurate coding for eye exams based solely on EMR entries
- Super-fast on-line response
- Significantly improved compliance
- Expert system without physician interrogation
- User prompts in challenging situations
- Broader utilization of available CPT and HCPCS codes
- Integrated with applicable CPT modifiers

MedFlow Mobile

MedFlow mobile allows doctors to access patient information on the go.

In fact, clients can quickly and efficiently access exams, prescriptions, history details, medications, patient images and more all from an outside table or mobile device.

Medflow Mobile is a safe and secure browser-based application that works on many platforms, including Apple, Blackberry and Android devices or any devices using the Apple, Android or RIM operating systems.

For more information, visit *www.foxfiresg.com*.

MEETINGS

March

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
LAUNCHING A SUCCESSFUL GLAUCOMA PRACTICE – SESSION #3
March 9, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
GLAUCOMA GRAND ROUNDS WITH LIVE PATIENTS
March 10-11, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

THE OHIO STATE UNIVERSITY COLLEGE OF OPTOMETRY
BINOCULAR VISION & PEDIATRICS FORUM
March 15, 2013
The Ohio State University College of Optometry, Columbus, OH
Marjean Taylor Kulp, O.D.
614/688-3336
Kulp.6@osu.edu
http://optometry.osu.edu/CE/BVPforum.cfm

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
SPRING MEETING
March 15-17, 2013
Kiawah Island Golf Resort, Kiawah, SC
www.kiawahresort.com
www.sceyedoctors.com

ALABAMA OPTOMETRIC ASSOCIATION PARAOPTOMETRIC TECHNICIAN COURSES
Level I – March 16
VisionAmerica, Birmingham, AL
Jo Beth Wicks
334/273-7895
jobeth@alaopt.com
www.alaopt.com

NDOA'S 2013 LEGISLATIVE AND CONTINUING EDUCATIONAL MEETING
March 21-22, 2013
Radisson Inn – Bismarck, ND
701/258-6766
FAX: 701/258-9005
ndoa@btinet.net
www.ndeyecare.com

TEXAS OPTOMETRIC ASSOCIATION AND THE UNIVERSITY OF HOUSTON
ABO BOARD CERTIFICATION REVIEW
March 23-24, 2013
Kmkoptometryboardcertification.org

ILLINOIS OPTOMETRIC ASSOCIATION
Winter CE
March 24, 2013
Tinley Park Convention Center, Tinley Park, IL
ioa@ioaweb.org
www.ioaweb.org

April

NOVA SOUTHEASTERN UNIVERSITY
NSU SEE NEW ORLEANS
April 5-7, 2013
New Orleans, LA
Vanessa McDonald
954/262-4224
FAX: 954/262-1818
oceaa@nova.edu
http://optometry.nova.edu/ce

IOWA OPTOMETRIC ASSOCIATION
115TH ANNUAL CONGRESS
April 5-7, 2013
Embassy Suites Downtown, Des Moines, IA
800/444-1772
515-222-5679
FAX: 515-222-9073
http://iowaoptometry.org

SOUTH DAKOTA OPTOMETRIC SOCIETY
SPRING CONVENTION
April 11-12, 2013
Cedar Shore Resort
Oacoma, SD
Deb Mortenson
605/224-8199
Sdeyes3@pie.midco.net

AMERICAN CONFERENCE ON PEDIATRIC CORTICAL VISUAL IMPAIRMENT
April 12, 2013
Children's Hospital & Medical Center, Omaha, NE
Sara M. Olson, M.Ed.
402/955-6070
FAX: 402/955-4162
solsen@childrensomaha.org

ALABAMA OPTOMETRIC ASSOCIATION
PARAOPTOMETRIC TECHNICIAN COURSE – LEVEL II
April 13, 2013
VisionAmerica, Birmingham, AL
Jo Beth Wicks
334/273-7895
jobeth@alaopt.com
www.alaopt.com

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
CORNEA & CONTACT LENS CE PROGRAM
April 14, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

WISCONSIN OPTOMETRIC ASSOCIATION
SPRING SEMINAR
April 17-18, 2013
Hyatt Hotel, Green Bay, WI
Joleen Breunig, Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

PINELLAS OPTOMETRIC ASSOCIATION
21ST ANNUAL SUNCOAST SEMINAR
April 20-21, 2013
Hyatt Regency Clearwater Beach Resort and Spa, Clearwater Beach, FL
Bruce Cochran
727/446-8186
888/421-1442 (Reservations)
IDoc1@aol.com

NEW JERSEY ACADEMY CHAPTER
11TH ANNUAL EDUCATIONAL CONFERENCE
April 24-28, 2013
Kingston Plantation, Myrtle Beach, SC
Dennis H. Lyons, O.D.
732/920-0110
Dhl2020@aol.com

2013 SPRING CONVENTION
ARKANSAS OPTOMETRIC ASSOCIATION
April 25-29, 2013
The Peabody, Little Rock, Arkansas
Vicki Farmer
501/661-7675
FAX: 501/372-0233
aroa@arkansasoptometric.org
www.arkansasoptometric.org

KENTUCKY OPTOMETRIC ASSOCIATION
2013 SPRING CONFERENCE
April 25-28, 2013
Hyatt Hotel & Convention Center
Lexington, KY
502/875-3516
sarah@kyeyes.org

UNIVERSITY OF CALIFORNIA, BERKELEY, SCHOOL OF OPTOMETRY
28TH ANNUAL MORGAN/SARVER SYMPOSIUM
April 26-28, 2013
DoubleTree Hotel, Berkeley Marina, Berkeley, CA
510/642-6547
FAX: 510/642-0279
optoce@berkeley.edu
http://optometry.berkeley.edu/ce/morgan-sarver-symposium

CE IN ITALY
April 26-27, 2013
Venice, Italy
James Fanelli, O.D.
910/452-7225
jamesfanelli@ceinitaly.com
www.ceinitaly.com

MIAMI NICE SYMPOSIUM 2013
April 27-28, 2013
Westin Colonnade Hotel, Coral Gables, FL
Dr. Steve Morris

305/668-7700
Mdopa.board@gmail.com
www.miamieyes.org

CE IN ITALY
April 29-30, 2013
Bolzano and the Italian Dolomite Alps, Italy
James Fanelli, O.D.
910/452-7225
jamesfanelli@ceinitaly.com
www.ceinitaly.com

May

MONTANA OPTOMETRIC ASSOCIATION
2013 ANNUAL EDUCATIONAL CONFERENCE & EXPOSITION
May 1-4, 2013
Hilton Garden Inn, Missoula, MT
406/443-1160
sweingartner@rmsmanagement.com
www.mteyes.com

COLLEGE OF SYNTONIC OPTOMETRY
81ST INTERNATIONAL CONFERENCE ON LIGHT AND VISION
May 1-4, 2013
St. Petersburg, FL
Ron Wahlmeier, MBA, ASCP
719/547-8177
syntonics@q.com

MOUNTAIN WEST COUNCIL OF OPTOMETRISTS
ANNUAL CONGRESS
May 2-4, 2013
Caesars Palace
Las Vegas, NV
888-376-6926
www.mwco.org

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
INDIAN HEALTH SERVICE
May 2-4, 2013
Biennial Navajo Area Meeting
Durango, CO
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

WISCONSIN OPTOMETRIC ASSOCIATION
BOARD CERTIFICATION REVIEW COURSE
May 3-4, 2013
Chula Vista Resort, Wisconsin Dells, WI
Joleen Breunig
Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
SPRING CE PROGRAM – A POTPOURRI OF CE
May 5, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY
COEUR D'ALENE CE
May 10-11, 2013
Coeur d'Alene Resort, Coeur d'Alene, ID
Jeanne Oliver
503/352-2740
FAX: 503/352-2929
jeanne@pacificu.edu
www.pacificu.edu/optometry/ce

ALABAMA OPTOMETRIC ASSOCIATION
PARAOPTOMETRIC TECHNICIAN COURSE – LEVEL III
May 11, 2014
VisionAmerica, Birmingham, AL
Jo Beth Wicks
334/273-7895
jobeth@alaopt.com
www.alaopt.com

MICHIGAN OPTOMETRIC ASSOCIATION
117TH ANNUAL MEETING AND SPRING SEMINAR
May 9-10, 2013
DeVos Place, Grand Rapids, MI
Amy Possavino
517/482-0616
FAX: 517/482-1611
amy@themoa.org
www.themoa.org

AEA CRUISES
OPTOMETRIC SEMINAR
May 11-18, 2013
Alaska-Inside Passage – Aboard the Star Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com
Post-ARVO Annual Meeting in Seattle

ARIZONA OPTOMETRIC ASSOCIATION
2013 SPRING CONGRESS
May 17-19, 2013
Hilton Tuscon El Conquistador Golf & Tennis Resort, Tucson, AZ
Kate Diedrickson
602/279-0055
FAX: 602/264-6356
kate@azoa.org
www.azoa.org

NOVA SOUTHEASTERN UNIVERSITY
17TH ANNUAL EYE CARE CONFERENCE AND ALUMNI REUNION
May 17-29, 2013
Fort Lauderdale, FL
Vanessa McDonald
954/262-4224
FAX: 954/262-1818
oceaa@nova.edu
http://optometry.nova.edu/ce

June

MCN Medizinische Congressorganisation Nürnberg AG
26th International Congress of German Ophthalmic Surgeons
June 13-16, 2013
Nürnberg, Germany, Messezentrum
++49/911/3931617
FAX: ++49/911/3931620
doc@mcnag.info
www.doc-nuernberg.de

OPTOMETRY'S MEETING
June 26-30, 2013
San Diego, CA
www.optometrysmeeting.org

July

AEA CRUISES
OPTOMETRIC SEMINAR
July 3-10, 2013
Alaska-Voyage of the Glaciers – Aboard the Coral Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
16-HOUR GLAUCOMA CASE Management with Certification Exam
June 8-9, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

NATIONAL OPTOMETRIC ASSOCIATION ANNUAL CONVENTION
July 10-14, 2013
Loews New Orleans Hotel
New Orleans, Louisiana
1-877-394-2020
www.nationaloptometricassociation.com

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
GLAUCOMA GRAND ROUNDS WITH LIVE PATIENTS
July 14-15, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

AEA CRUISES
OPTOMETRIC SEMINAR
July 17-29, 2013
Grand Mediterranean – Aboard the Royal Princess
888/638-6009
aeacruises@aol.com
www.optometriccruiseseminars.com

PACIFIC UNIVERSITY COLLEGE OF OPTOMETRY
2013 VICTORIA CONFERENCE
July 18-21, 2013
Delta Ocean Pointe Resort, Victoria, BC, Canada
Jeanne Oliver
503/352-2740
FAX: 503/352-2929
jeanne@pacificu.edu
www.pacificu.edu/optometry/ce

IOWA OPTOMETRIC ASSOCIATION
OKOBOJI OPTOMETRIC MEETING
July 19-21, 2013
The Inn, Okoboji, IA
800/444-1772
515-222-5679
FAX: 515-222-9073
http://iowaoptometry.org

SOUTHERN CALIFORNIA COLLEGE OF OPTOMETRY
OCULAR DISEASE PART II – ALL THERAPEUTIC CE PROGRAM – 2 DAYS
July 20-21, 2013
SCCO Campus, 2575 Yorba Linda Blvd.
Fullerton, CA 92831-1699
Antoinette Smith or Bonnie Dellatorre
714/449-7495
ce@scco.edu

NORTHERN ROCKIES OPTOMETRIC CONFERENCE
July 25-27, 2013
Jackson, Wyoming
Coby Ramsey, O.D.
cramsey@wyoming.com

NOVA SOUTHEASTERN UNIVERSITY
NOVA SEE ST. SIMONS ISLAND
July 26-28, 2013
St. Simons Island, GA
Vanessa McDonald
954/262-4224
FAX: 954/262-1818
oceaa@nova.edu
http://optometry.nova.edu/ce

ALABAMA OPTOMETRIC ASSOCIATION
SUMMER CONFERENCE
July 26-27, 2013
Sandestin Hilton, Destin, FL
Jo Beth Wicks
334/273-7895
jobeth@alaopt.com
www.alaopt.com

TAHOE SUMMIT 2013
July 26-28, 2013
Hyatt Regency at Incline Village, NV
916/447-0270
jerrysue@svos.info

August

ALASKA OPTOMETRIC ASSOCIATION
ANNUAL SUMMER CONFERENCE
August 1-4, 2013
Wedgewood Resort, Fairbanks, AK
AKOA@alaska.com
www.akoa.org

WISCONSIN OPTOMETRIC ASSOCIATION
SUMMER EDUCATION EVENT
August 2-3, 2013
Blue Harbor Resort, Sheboygan, WI
Joleen Breunig, Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

COLORADO VISION SUMMIT
August 3-4, 2013
Crowne Plaza Hotel DIA
Denver, CO
303/863-9778
www.coloradovisionsummit.org

SOUTH CAROLINA OPTOMETRIC PHYSICIANS ASSOCIATION
ANNUAL MEETING
August 22-25, 2013
Myrtle Beach Marriott Resort and Spa at Grande Dunes, Myrtle Beach, SC
www.sceyedoctors.com

September

ENVISION CONFERENCE 2013
September 19-21, 2013
Hyatt Regency Minneapolis, Minneapolis, MN
info@envisionconference.org
www.envisionconference.org

NOVA SOUTHEASTERN UNIVERSITY
FALL CONFERENCE
September 21-22, 2013
Fort Lauderdale, FL
Vanessa McDonald
954/262-4224
FAX: 954/262-1818
oceaa@nova.edu
http://optometry.nova.edu/ce

SOUTH DAKOTA OPTOMETRIC SOCIETY
FALL CONFERENCE
September 26-27, 2013
Rushmore Plaza Holiday Inn
Rapid City, SD
Deb Mortenson
605/224-8199
Sdeyes3@pie.midco.net

WISCONSIN OPTOMETRIC ASSOCIATION
CONVENTION AND ANNUAL MEETING
September 26-29, 2013
Kalahari Resort, Wisconsin Dells, WI
Joleen Breunig, Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

KENTUCKY OPTOMETRIC ASSOCIATION
2013 FALL CONFERENCE
September 27-29, 2013
Louisville, KY
502/875-3516
sarah@kyeyes.org

NDOA'S 110TH ANNUAL CONGRESS AND EXHIBITION
September 29-October 1, 2013
Ramada Plaza Suites, Fargo, ND
701/258-6766
FAX: 701/258-9005
ndoa@btinet.net
www.ndeyecare.com

October

Connecticut Association of Optometrists
Annual Education Conference
October 5-7, 2013
Mystic Marriott Hotel & Spa
Lynn Sedlak, CAE, MBA
860/529-1900
lsedlak@cteyes.org
www.cteyes.org

College of Optometrists in Vision Development
43rd Annual Meeting
October 8-12, 2013
Rosen Shingle Creek, Orlando, FL
330/995-0718
www.covd.org

WISCONSIN OPTOMETRIC ASSOCIATION
NORTHWOODS EDUCATION EVENT
October 11-12, 2013
Grand Pines Resort, Hayward, WI
Joleen Breunig, Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

IOWA OPTOMETRIC ASSOCIATION
HAWKEYE INSTITUTE
October 17-18, 2013
Marriott, Cedar Rapids, IA
800/444-1772
515-222-5679
FAX: 515-222-9073
http://iowaoptometry.org

AMERICAN ACADEMY OF OPTOMETRY
ACADEMY 2013 SEATTLE
October 23-26, 2013
Seattle Convention Center
www.aaopt.org

November

ALABAMA OPTOMETRIC ASSOCIATION
ANNUAL CONVENTION
November 8-10, 2013
Birmingham, AL
Jo Beth Wicks
334/273-7895
jobeth@alaopt.com
www.alaopt.com

WISCONSIN OPTOMETRIC ASSOCIATION
PRIMARY CARE SYMPOSIUM
November 8-9, 2013
Madison Marriott West Hotel, Middleton, WI
Joleen Breunig, Member Services Director
608/824-2200
joleen@woa-eyes.org
www.woa-eyes.org

For featured calendar events, email t.peppers@elsevier.com.

To submit standard items for the meetings calendar, send a note to eventcalendar@aoa.org.

Please allow several months' lead time.

American Optometric Association

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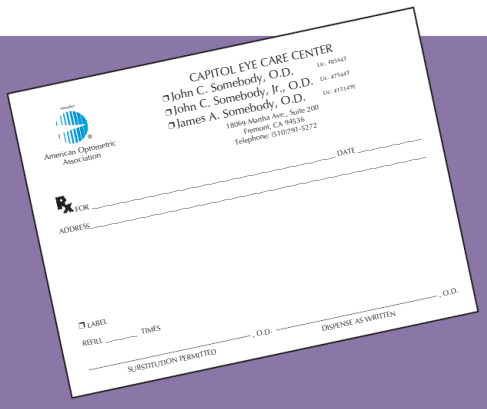

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7. Eliminates third party involvement
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familyvisioncenter@nts-online.net

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Miscellaneous

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References: 1. In a randomized, subject-masked clinical study at 20 sites with 252 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2009. **2.** Rappon J. Center-near multifocal innovation: optical and material enhancements lead to more satisfied presbyopic patients. *Optom Vis Sci.* 2009;86:E-abstract 095557. **3.** In a randomized, subject-masked clinical trial at 6 sites with 47 patients; significance demonstrated at the 0.05 level; Alcon data on file, 2008. **4.** Based on a third-party industry report, 12 months ending October 2012; Alcon data on file.

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